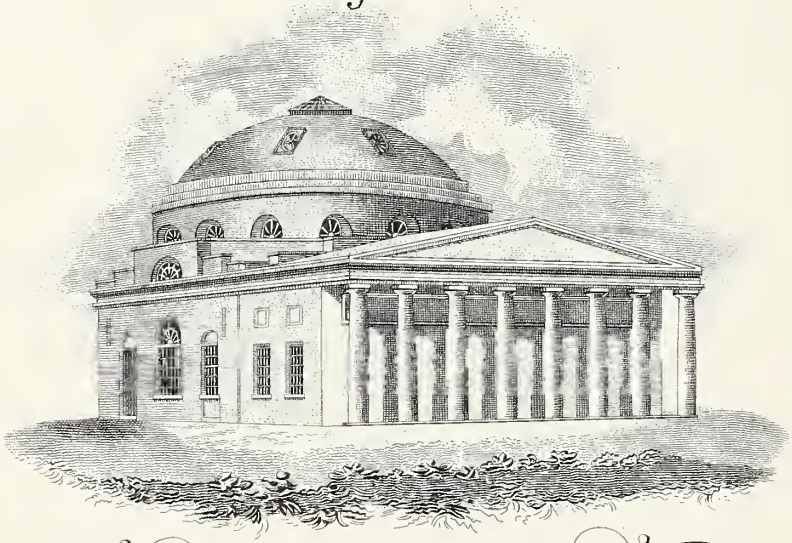
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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, January, 1947 No. 1

Blood Transfusion and Transfusion Reactions

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I. *Introduction:*

That the blood transfusion has become firmly established as a therapeutic method is borne out by the bare statistics of the number of transfusions given in a few representative hospitals in the last few years.

	Beds	Transfusions 1941	1942	1943	1944	1945
Massachusetts Memorial Hospitals *	418	626	931	940	1344	1572
Beth Israel Hospital (Boston) **	215			728	665	808
Cambridge Hospital ***	221			208	320	673

The increasing use of transfusion therapy is due to several factors, (1) ready availability of blood, (2) simplicity of administration and, (3) awareness of the great value of blood in various clinical conditions. There can be no doubt, however, that the ready availability of blood tends to make its use frequent when indications are by no means well defined. The administration of blood is, furthermore, not without danger. For these reasons, it becomes of some importance to review the various uses and abuses of transfusions, to cite some of the dangers involved and to point a few morals.

II. *Historical:*

Between Landsteiner's discovery of the blood groups in 1900,[1] and the use of this important knowledge in clinical practice, there was a time lag of at least 10 years. As a result, transfusion therapy was but little used during the early years of the first World War. In the period of 1918 to 1925, much discussion ensued regarding the relative merits of whole, unmodified and citrated blood. Transfusions

Presented at the annual meeting of the Massachusetts Medical Society, Boston, May 23, 1946.

* I am indebted to Dr. Joseph F. Ross for these figures.

** I am indebted to Dr. Benjamin Alexander for these figures.

*** I am indebted to Dr. A. G. Engelbach and Miss Wilson for these figures.

were almost a major operative procedure and as such were carried out with all the panoply of an operating-room organization.

Gradually, as citration of blood was found to be simple, harmless and unproductive of little if any change in the character of the red cells, leukocytes, and platelets, a revolution in transfusion methods took place. The operating room gave way to the bedside; the surgical team to the resident or interne or even to the nurse or technician; and the surgical "cut-down" on a vein to the more simple veni-puncture. Since the donor could be venesected in one part of the hospital and his blood taken at leisure to the recipient, it was a natural step to the "blood bank." This constant simplification of methods, together with the inevitable increase in availability of blood naturally led to its wider and wider use, so that now the bottle hanging by the bedside with blood dripping slowly into the patient's veins has become a common hospital sight.

This is a far cry from that era in medicine a century and more ago when blood-letting was the therapeutic procedure of choice in conditions ranging from pneumonia to typhoid fever, and from jaundice to diarrhea. Today, blood-letting except under certain special conditions such as polycythemia and right-sided heart failure, has been relegated to the limbo of forgotten things. Can it be that transfusions may some day be less widely used than they are now?

III. *A Short Review of the Blood Groups, Agglutinins, Etc.*

The laboratory procedures of typing and cross-matching carry with them the possibilities of life and death to the transfused individual, since an error in technique may be fatal. It therefore behooves the physician who orders or gives a transfusion to have a working knowledge of the blood groups and their agglutinating substances. Human red cells contain agglutinable substances called *agglutinogens*. Either A, B, A and B, or no agglutinogens may be present. Thus, four types of blood according to their agglutinogen content may be discriminated: A, B, AB, and O, the latter lacking both agglutinogens A and B.

Simultaneously, the plasma contains agglutinating substances called agglutinins. Curiously enough, and for no obvious reason, human blood of type A simultaneously possesses in the plasma anti-B agglutinin, and type B contains anti-A agglutinin. AB blood has no agglutinins in the plasma, whereas O blood, containing no agglutinogens in the red cells is associated with both agglutinins, anti-A and anti-B, in the plasma.

The red cells may contain agglutinogens other than those belonging to the A-B-O system, i.e. the M and N factors, the Rh factor, etc. Some of these, for example the M and N factors, have no importance from the standpoint of transfusions but are useful in certain medico-legal situations having to do with disputed paternity, baby-changing in nurseries, etc. On the other hand, the presence or absence within the red cell of the Rh agglutinogen is of decided importance in transfusion therapy since the Rh factor is a potent immunizer. An individual lacking this factor (i.e. Rh negative) can become iso-immunized and develop the anti-Rh agglutinin when given successive transfusions of Rh positive cells. Or, a woman who is Rh negative and who is pregnant can become isoimmunized by the fetus in utero with the resultant development of anti-Rh agglutinin. This may result in intravascular agglutination and hemolysis in the mother if she is given Rh positive red cells or may cause hemolysis in the fetus if the agglutinin enters the fetal circulation which contains Rh positive red cells.

Some agglutinins are "warm" (i.e. act optimally at temperatures of 37° C, e.g. the anti-Rh agglutinin), others "cold" (i.e. act at ice-box temperature, e.g. the cold hemagglutinin) and still others are effective at all temperatures (the anti-A and anti-B agglutinins). Some are *iso*-agglutinins (reacting with red cells of the same species), others *hetero*-agglutinins, and still others *pan*-agglutinins, reacting with red cells from several animal species.

Agglutinins cause the red cells to clump in bunches like grapes. Tests for anti-A, anti-B, and anti-Rh agglutination are best done in the test tube at incubator temperature, rather than on the slide at room temperature. The latter method is much less sensitive and may lead to the report of a false-negative in the cross-matching test. However, a special slide test

using heavy suspensions of oxalated or citrated red cells has recently been used for detecting the Rh "blocking" antibody.[2] The test is apparently effective because of the presence of plasma. Thus, when whole plasma or its albumin fraction are substituted for salt solution as a diluent of the serum to be tested, positive reactions of agglutination can also be obtained.

IV. *Indications for Transfusions:*

Some doubt may be expressed regarding the actual necessity for the use of the very large number of transfusions which are being administered. What are they being used for? This varies with the hospital and the individual physician. In many hospitals the major surgical operation has become the most common indication for the use of transfusion therapy. The use of one or more transfusions before serious gastro-intestinal or pulmonary operations, particularly if any degree of anemia is present has become almost routine. During operation, the constant dripping of blood into the patient's veins is at once a reassuring sight to the surgeon and doubtless a mainstay to the patient's circulation. In some large municipal institutions cases of serious trauma, burns, etc., may be numerous, whereas in a hospital specializing largely in medical problems, vascular collapse may be rare and chronic anemia and hypoproteinemia much more common. By and large, however, transfusions are being used chiefly in the following conditions:

(1) Major surgical operative procedures—before, during and after operation.

(2) Following severe hemorrhage.

(3) In conditions of shock — hemorrhagic, traumatic, burn, infections.

(4) In severe anemia of diverse origins.

(5) In miscellaneous hematologic problems, including agranulocytosis, leukemia, thrombocytopenic purpura, hemophilia and other hemorrhagic diseases.

(6) In conditions of hypoproteinemia; and finally

(7) In the presence of such conditions as "low vitality," prolonged convalescence, delayed wound healing and chronic infections.

Following operation, the administration of blood and intravenous fluids, the installation of tubes in various orifices and the use of all manner of mechanical appliances have revolutionized the practice of surgery and cut the mortality rate sharply. Although there can be no doubt regarding the value of these measures, one sometimes wonders whether they are not being overdone. For example, in the presence of a mild, chronic anemia to which the patient's circulation has undoubtedly become well adjusted, a transfusion given prior to operation may not only be useless, but potentially dangerous. In the presence of severe anemia, the wisdom of giving large volumes of blood within a few days and then operating may be seriously questioned. The circulation has hardly had a chance of becoming adjusted to this large new volume of blood and it seems unlikely that the tissues would benefit very much from the new amount of oxygen carrying material. From the physiologic standpoint, it is far better to improve the patient's anemia slowly by appropriate medical therapy (such as iron) if this can feasibly be done.

During operation, the use of transfusion has become a standard procedure and may well contribute to the diminishing incidence of vascular collapse. A note of caution should be sounded. The anesthetized patient may show no indications of the presence of a severe reaction of agglutination, the deleterious effects only coming to light at a later hour.

Following operation, fluids of various types including blood are poured into the patient. This may well be overdone, particularly in the older age groups, since the pulmonary circuit must be the first to bear the brunt of a sudden increase in blood volume, with the result that pulmonary edema not infrequently develops.

The urgent indication for the use of blood in severe hemorrhage and in the various types of shock state: traumatic, burn and infectious hardly needs recapitulation at this time. Even under such circumstances, no proper safeguard should be relaxed. While impatiently waiting for the laboratory report, the surgeon may meanwhile begin the administration of plasma, which in many respects is a better material than whole blood for cases of peripheral vascular collapse.

In severe anemias of diverse origin: aplastic, hemolytic, leukemic, etc., transfusions are often essential either as a temporary measure while awaiting some other procedure such as splenectomy or as the only measure of any value at all. Similar situations hold true in other hematologic problems: for example in agranulocytosis, to increase slightly the number of leukocytes; in thrombocytopenic purpura, to add platelets while awaiting possible splenectomy, in hemophilia to add a normal plasma factor and thus control hemorrhage. The use of red cell concentrates should be encouraged, particularly in refractory cases of anemia. Red cells derived from plasma banking programs may readily be given in double or triple the numbers which are ordinarily administered.

Under conditions of hypoproteinemia — chronic liver disease, sprue, chronic nephrosis, ascites, starvation, deficiency states—blood may be given to cause a quick increase in the protein values. Plasma may be used if the red cells are not greatly diminished.

Blood has become so freely available and is administered so easily that it is no wonder that its administration is at times abused. The value of blood in improving the patient's immunity or resistance during subacute or chronic infections is very doubtful, and one can hardly agree with the conclusions of certain Russian authors[3] that blood adds a "vital" factor which is useful in convalescence from wounds and sickness and in such vague conditions as "debility." Even so, there can be no doubt that some transfusions are being given because they help to dramatize a given situation and to indicate that something "definite" is being done.

The various indications for transfusions may be listed as follows:

A. *Absolute:*

(1) Severe hemorrhage, generally over 1000 cc.

(2) Certain hematologic problems: the hemolytic crisis, severe hemolysis or hemoglobinuria.

(3) Shock—hemorrhagic, traumatic, burn, infectious (plasma may be better here).

B. *Relative:*

(1) In association with major surgical operations: before, during and after operation.

(2) Various types of severe anemia.

(3) Severe hypoproteinemia.

C. *Dubious:*

(1) In chronic infections.

(2) To improve vitality, convalescence and wound healing.

D. *Outrageous:*

(1) As a dramatic gesture.

V. *The Dangers of Transfusions:*

The subject of transfusion therapy would hardly require discussion at this time were it not for the fact that the administration of blood is not without its danger. This may be either circulatory or associated with various types of reactions which may occur within the blood stream.

The quick introduction into a vein of a pint or more of blood results in distension of the right auricle and in a sudden rise of intravascular pressure. Considerable increases may occur in the venous pressure, the cardiac output and perhaps in the velocity of blood flow. If blood is given at a rate greater than 20 cc. per minute, "speed shock"[4] may develop. The rapid introduction of quantities of blood larger than 500 cc. may result in more or less marked pulmonary edema. This is particularly true in the anemic elderly individual, who not only has a rigid type of vascular apparatus but a more or less weakened myocardium. Cough, dyspnea, wheezing, orthopnea, and in extreme cases all the symptoms of pulmonary edema may result. Even relatively minor reactions may be productive of profound circulatory abnormalities, with the sudden precipitation of heart failure or coronary occlusion. For this reason, transfusions in the elderly subject must be administered with unusual caution and the blood be given at no greater a rate than 2 cc. per minute (at least four hours for a transfusion of 500 cc. of blood).

The most common of the dangers involved in transfusion have to do with various types of

non-circulatory reactions. These may be classified as (a) not very significant, (b) significant but not serious, and (c) serious. Minor reactions occur commonly and include such subjective complaints as headache and malaise, slight chilly sensations, and the appearance of an urticarial eruption.

For the most part these are probably allergic in nature. Significant, but not serious reactions occur in from 5-10% of all transfusions, and usually consist of chills and fever, at times very marked. Towards the end of the transfusion, or shortly after its completion, the patient complains of cold and then begins to shake violently. After varying lengths of time, the shaking chill subsides to give rise to a sharp rise in temperature. The urine shows no change in color and there is a complete lack of hemoglobin by the benzidine test. The blood plasma shows no demonstrable increase in plasma hemoglobin. Although these reactions which are commonly called pyrogenic, are disconcerting, they can hardly be classed as serious except in the occasional debilitated elderly person with an impaired myocardium and chronic anemia. They are usually due to the presence of foreign material either in the rubber tubing, the solutions or in the blood itself. This material may be composed of killed bacterial organisms, bits of coagulated blood, partially deteriorated rubber from old tubing, etc. Similar reactions may occur with the use of fluids alone and are therefore not necessarily due to the blood as such.

The most serious transfusion reaction is that of intravascular hemagglutination due to the interaction of an agglutinin in the patient's plasma with an agglutinogen in the donor's red cells. Most commonly, this is brought about by an error in blood grouping or cross-matching as when a group O individual, containing in his plasma anti-A and anti-B agglutinins, is given blood from an individual of A or B blood group. Errors may also occur when the cross-matching has been omitted, or when a bottle of blood from the blood bank has been mislabeled. Occasionally an individual donor having a weak A agglutinogen is miscalled O. This is particularly true in the presence of weak typing sera, or sera which have become contaminated with bacterial growth. More common perhaps than A-B-O reactions are those dealing with the Rh factor.

The agglutination reaction which takes place within the circulation proceeds approximately as follows:

(1) The red cells agglutinate in large masses within various parts of the circulation, including the glomeruli of the kidneys.

(2) Intravascular agglutination leads to intravascular hemolysis due to the mechanical trauma of the constantly pulsating circulation upon the agglutinated red cells; these have an increased mechanical fragility. Intravascular hemolysis leads to hemoglobinemia and to hemoglobinuria.

(3) In the acid reacting renal tubules the hemoglobin from the hemolyzed red cells becomes modified to colloidal acid hematin. The renal tubules become plugged with insoluble acid hematin casts leading to a tubular nephrosis. This may terminate in all the various evidences of renal shutdown with uremia and death.

(4) The initial intravascular hemolysis gives way to a more orderly type of hemolysis with bilirubinemia, jaundice, an increased output of urobilinogen in the urine, etc.

Clinically, during the administration of the first 50 to 100 cc. of blood, the patient usually complains of a vague sense of malaise, a sense of constriction in the chest, a feeling of suffocation, pain in the flanks, and then in the thighs. Dyspnea may become agonizing and the pain so severe as to result in loud cries. The teeth begin to chatter, and the patient then has a violent chill. Cyanosis and vascular collapse may develop. The first urine passed may be clear and normal in color (bladder urine) but later urine specimens, due to their contained hemoglobin, are mahogany-brown or burgundy-red in color.

The urine output soon becomes sharply reduced. Within 24 hours, often only from 5 to 20 cc. of murky urine are being passed, containing large amounts of hemoglobin, albumin and casts. In another day or two, the puffiness of acute nephrosis becomes evident, and in a few days, the full-blown symptoms of uremia are in evidence. Finally, the patient either lapses into coma and dies or suddenly begins to pass urine and recovers.

The degree of hemolytic jaundice which develops varies greatly. As the hemoglobinemia

due to intravascular hemolysis diminishes, the ordinary mechanisms of blood destruction take over with resultant bilirubinemia of the indirect variety. In some cases, this becomes marked with the development of severe anemia and leukocytosis but in others, very little evidence of increased hemolysis is present.

The severity of the reaction and the degree of rapidity of its development depend upon several factors, of which the most important is the amount of blood introduced into the patient's circulation. When less than 50 cc. are given, a sharp chill and fever result with a minimal amount of hemoglobinuria. The administration of 100 to 200 cc. of blood is compatible with life, but when more than 200 cc. are given, death usually occurs. Another important factor is the potency of the recipient's agglutinin. In the presence of a strong agglutinin, a small amount of blood may be completely agglutinated with a resultant severe reaction. However, when a relatively weak agglutinin such as the anti-Rh "blocking" antibody is present, the reaction may be slow in its development and less likely to cause death.

The treatment of a severe intravascular agglutination reaction is far from satisfactory. Large amounts of fluid should be given. Although alkalinization with solutions of sodium bicarbonate or sodium lactate have been recommended for their effect in diminishing the formation of acid hematin plugs,[5] I have found them of only questionable value.

Hypertonic solutions of salt, dextrose and plasma may be used in the attempt to reduce the tubular swelling. Whether any of these methods is of any particular value is debatable, although the continued introduction of fluids is certainly desirable. Caution should be expressed that the use of too heroic quantities of fluid may kill rather than cure. In about one case in ten, the patient suddenly begins to pass small, then large quantities of urine and makes a complete recovery. The renal abnormality is therefore, at least in some cases, reversible. This reversibility has been taken advantage of in a method which holds some promise in the treatment of the intravascular hemagglutination reaction.

By instilling into the peritoneal cavity large quantities of fluid containing a suitable concentration of appropriate electrolytes (Tyrode's solution is preferred), Seligman, Frank and Fine[6] have utilized the peritoneum as a dialyzing membrane which will remove from the blood stream the various non-protein substances causing uremia. By maintaining a constant flow of fluid through the peritoneum, an extra-renal but kidney-like action can be maintained until the kidneys themselves begin to function.

Another complication of transfusion therapy which has only recently begun to be appreciated is the development of infectious hepatitis (homologous serum jaundice) which occurs not only with the administration of whole blood but following the introduction of plasma and albumin solutions.[7] This condition is brought about by the presence of a persistent slowly incubating virus in the donor's blood stream. It has been shown that virus of infectious hepatitis may withstand long exposure and may cause a severe hepatitis in the recipient several weeks to months after the blood or blood substitute has been introduced.

VI. *The Prevention of Transfusion Reactions:*

The treatment of a full-blown hemagglutination reaction is often a thankless job, and until very recently has rarely been productive of a live patient.

The crux of the situation is therefore its prevention: this aspect of the problem requires the greatest emphasis. In preventing a transfusion reaction three types of individuals—exclusive of the patient—are concerned: they are the physician, the technician (or a junior interne acting as such), and the nurse. The physician in charge of administering the transfusion must ask himself: "Is this transfusion truly necessary? Can I possibly get along without it? Can I perhaps use intravenous fluids, plasma or some other blood substitute?" Once he has assured himself that there exists a definite indication for the transfusion, the next step is to be sure that his patient will get (a) the correct blood and (b) the blood correctly. This requires the help of certain technically trained personnel, but here too, the physician has his responsibilities. He should see to it that the donor is free of syphilis. Individuals with a possible exposure to malaria as well as

those having had an attack of jaundice should be routinely discarded as donors. For the severely anemic patient and for one with any sort of a blood dyscrasia it is advisable to use fresh and not bank blood.

Group O or "universal donor" blood may be used even for recipients of Groups A, B, and AB unless the patient happens to be severely anemic or has an acute hemolytic anemia. Under such circumstances, the anti-A and anti-B agglutinins in Group O blood may agglutinate the relatively few red cells in the recipient's circulation. This can be obviated by the use of Witebsky's A and B substances,[8] which when added to the donor's blood, neutralize the anti-A and anti-B agglutinins.

In the case of a female of whatever age, from the age of 1 day to 90 years, the use of Rh negative blood should always be contemplated as a possibility unless the recipient is definitely known to be Rh positive. An infant or a little girl who is Rh negative may become iso-immunized even with one transfusion of Rh positive blood and retain this immunization in her tissue for many years.[9]

When she grows up and is married—usually to an Rh positive individual — her first child may be erythroblastotic because the antibodies previously built up will become activated during the present pregnancy and will react upon the fetus in utero.[9] Ordinarily, an Rh negative woman may have one or even two normal children before giving birth to an erythroblastotic infant but her only chance may be invalidated by the administration of an Rh positive transfusion given years previously. In an Rh negative woman beyond the child-bearing age, antibodies may have been formed in previous years during pregnancy. Women in pregnancy, during labor, or in the puerperium are particularly vulnerable should a transfusion be required, since if they are Rh negative, they may have circulating antibodies and thus react adversely to the introduction of Rh positive blood. Particularly in the female of the species, therefore, the physician should see to it that (a) the transfusion be given only if absolutely essential, (b) the Rh type be determined, (c) Rh negative blood be given if the proposed recipient is Rh negative.

In a person, male or female, receiving multiple transfusions and in one having received transfusions in the past, Rh typing should always be done since the recipient may be Rh negative and thus have built up anti-Rh agglutinin. If Rh negativity is present, the patient should receive only Rh negative blood.

The elderly recipient of blood as already noted, should receive blood very slowly if at all. In the baby or the young child, the use of special apparatus including syringes and needles may be required. The resident on a pediatric service or in the hospital for children or the physician with specialized training in giving fluids to children should be utilized as far as possible for the often difficult matter of giving blood to the infant either into the scalp veins, the external jugular vein, or in some instances by way of the bone-marrow.

Once the necessary decisions have been made as to the desirability of the transfusion and its mode of administration, the physician must assure himself of the correctness of the typing and cross-matching procedures. These are often relegated to the "pup" interne, but are now usually carried out by more or less well-trained technicians. A visit to the laboratory to observe the methods used in typing and cross-matching will often be salutary. A few of the questions which might reasonably be asked are: "What manner of typing sera are being used? Are they of high or low titer? What precautions are maintained for keeping them free from bacterial contamination? Are anti-Rh testing sera freely obtainable? Where do they come from? Do they give few or many Rh negative reactions? How are the cross-matching tests performed: by the slide method, the test tube method, at incubator temperature? Are they checked? By whom? Is there any follow-up of reactions?"

An important question, perhaps more so than most of the others, is that of the amount of time given to the typing and cross-matching. Does the technician feel hurried? Does she have so many other duties that she feels she does not have time enough to evaluate properly her results? Does she have the opportunity to keep up with modern techniques and changes in methods? Is she checked by a physician? Does she have refresher courses, etc.?

It should be realized that technicians are

quite necessary tools. They give the physician "an extra pair of hands;" but in no case should they replace him or take the entire responsibility of an often life-and-death decision. If the technician is the "hands" the physician should be the "brains." He should, or some one physician should, constantly supervise the technician and see to it that a maximum of safeguards is being maintained, thus resulting in a minimum of errors.

Once the blood is ready to be given, the nurse comes into the picture. The physician inserts the needle and observes whether the blood is running in freely, and at a rate not greater than 4 cc. per minute. The remainder of the transfusion is often left in the hands of the nurse. Like other humans, nurses vary in their observational ability, their knowledge, and their sense of responsibility. The bright, conscientious nurse watches the patient closely and if he complains of a peculiar sensation, dyspnea, pain in the flank, etc., immediately notifies the physician and/or removes the needle from the vein. Too often though, the nurse may, when the patient complains of a pain or a peculiar sensation, calmly pat him on the shoulder and say, "Now, don't be worried; there is nothing wrong, you will be all right!" In the meantime, the blood keeps dripping in.

The transfusion should be watched with particular care during the administration of the first 50 to 100 cc. because it is during this period that the reaction of intravascular hemagglutination almost invariably takes place. Thus, at the patient's first complaint of a peculiar sensation such as dyspnea, loin pain, pain down the legs, etc., the transfusion should be immediately stopped. Errors of commission may well be made but these are to be preferred to the serious transfusion reactions. The nurse should therefore be carefully drilled in the various symptoms of the transfusion reaction, and in the necessity for removing the needle if any of these symptoms occur. The *in vivo* reaction of the patient is more important in many respects than the laboratory tests done on slide or in test-tube.

This brings up yet another question namely, the increasing frequency with which transfusions are being used in the anesthetized patient either before, during or after operation. The patient who is unconscious from ether or some other anesthetic agent, certainly cannot respond to the sensations elicited by the reaction of intravascular hemagglutination, and thus the *in vivo* test is lost.

This makes it all the more important that unless the transfusion is absolutely essential it should not be given during operation. A transfusion may well be given the day before or completed just prior to operation or it may be postponed until after operation when the patient is out of anesthesia. This to be sure is contrary to the often considered necessity of giving blood during operation as a prophylactic measure against the development of shock. However, would it not be more desirable to give plasma under such circumstances?

VII. *Summary:*

1. Transfusions of blood have become a commonly employed therapeutic measure and their use is increasing rapidly from year to year. Is it possible that they are being used too frequently? What are the dangers involved? How may they be prevented?

2. The use of transfusion therapy requires a certain minimal knowledge relating to agglutinins, agglutinogens, the Rh factor, and the physiologic pathology of the reaction of intravascular hemagglutination.

3. Transfusions are being given for a large number of conditions in some of which their use may be questioned. The indications for transfusion may be listed as follows:

(a) *Absolute:*

1. Severe hemorrhage, generally over 1000 cc.
2. Certain hematologic problems, notably the hemolytic crisis, severe acute hemolysis (including erythroblastosis fetalis) severe thrombocytopenic purpura, bleeding in hemophilia.
3. Shock, traumatic, hemorrhagic, burns, etc. (but plasma may be preferable here).

(b) *Relative:*

1. In association with major surgical procedures: before, during, or after operation.

2. Severe anemia of diverse origin.
3. Severe hypoproteinemia.

(c) *Dubious:*

1. In chronic infections.
2. To improve vitality, convalescence, wound healing, etc.

(d) *Outrageous:*

1. As a gesture.

4. Transfusions are not without danger. Reactions which occur are of two main types:

(a) A disturbance in the cardio-vascular apparatus; this is particularly common in the elderly.

(b) Reactions due to the blood itself:

(1) Not very significant — i.e. allergic, slight headache, etc.

(2) Significant, but not serious—i.e. pyrogenic.

(3) Serious: intravascular hemagglutination. These are often fatal, depending in part upon the amount of blood given and the strength of the agglutinin.

5. The serious reaction of intravascular hemagglutination leads to hemolysis, but more important to a condition of tubular nephrosis, uremia and usually death. Treatment of the severe agglutination reaction is often valueless, although recent advances, chiefly with the use of intraperitoneal dialysis, may become significant.

6. The serious transfusion reaction is best treated by its prevention. This requires the complete coöperation of the physician, the technicians and the nurse and points up a series of morals.

VIII. *Morals:*

1. The physician giving or ordering a transfusion must ask himself: "Is it absolutely necessary?" Having answered this in the affirmative, he must bend every effort to prevent a serious transfusion accident.

2. Transfusions in females of any age must be approached with unusual caution because of the possible development in the past or with the present transfusion of Rh iso-immunization. Thus girls — later possible mothers; mothers in childbirth; even grandmothers should be tested for the Rh factor and Rh negative blood used if indicated. This is also true for individuals, male *or* female, being given, or having received in the past, multiple transfusions.

3. The elderly recipient of a transfusion must be given blood very slowly, lest some cardiovascular complication ensues. In the very young, overloading of the circulation with too much blood must be avoided.

4. The technical matters of typing and cross-matching require constant supervision. There are no laboratory procedures in which the results of erroneous technique or interpretation can be more disastrous. They should not be relegated to improperly trained physicians and technicians. Sufficient time and constant checking are required. The physician may well keep in touch with the laboratory to see that such checks are being carried out.

5. The first 50 to 100 cc. of the transfusion are by all odds the most important since it is during this period that the most severe reactions take place. This requires careful supervision by the physician or by a well-trained nurse who is fully aware of her responsibilities. The *in vivo* reaction may pick up an incorrect cross-match, providing the nurse who watches does not "pooh-pooh" the patient's complaints. It is better to remove the needle early than to attempt to cope with the reaction induced by the administration of 200 or more cc. of blood.

6. Since the symptoms of the *in vivo* reaction are eliminated during anesthesia the actual necessity for the administration of whole blood during major operative procedures might well be reviewed.

References

1. Landsteiner, Karl: Zentralbl. f. Bacteriol., Parasitenk. u. Infections krankh. 27:357, 1900.
2. Diamond, L. K., and Abelson, N. M.: The demonstration of anti-Rh agglutinins—an accurate and rapid slide test. *J. Lab. and Clin. Med.,* 30:204, 1945.
3. Bagdassarov, A.: *Brit. Med. J.* 2:4267, 1942., Bogomolets, A.: *Am. Rev. Sov. Med.* 1:101, 1943.
4. Altschule, Mark D., and Gilligan, D. Rourke: The Effects on the cardiovascular System of Fluids administered intravenously in man. II. The Dynamics of the circulation. *J. Clin. Invest.,* 17:401, 1938.

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Pica: Its Relationship to Lead Poisoning in Children

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Every pediatrician encounters a certain number of children who persistently, often to their parents consternation, eat a variety of bizarre substances, such as hair, dirt, plaster, ashes, and animal excrement. To a certain degree, this tendency is normal during infancy, but when it continues throughout the second and even third year of life it is considered to be a definite abnormality. The term "pica" has been widely used in pediatric literature to denote this phenomenon. Pica has been frequently observed in mentally deficient children, and in certain sections of this country some correlation has been reported between pica and parasitic infestation of the gastrointestinal tract, especially hookworm disease. However, the majority of children exhibiting morbid appetite seem to be in good physical and mental health. In this group, pica has long been suspected of being a manifestation of some underlying nutritional deficiency.

During the last decade, abundant evidence has been presented that a dietary deficiency of iron, resulting in a microcytic hypochromic anemia, may cause gastric anacidity in children, and that an appreciable number of these children will develop pica.[2, 4, 5, 9] The primary purpose of this paper is to emphasize the fact that, although pica is by and large regarded with little concern by physicians, serious and even fatal cases of lead poisoning may occur in these children following the ingestion of lead-containing paint from furniture and woodwork.

As the following cases illustrate, the treatment of acute lead poisoning is far from satisfactory. The mortality has been reported from 20% in some series to 50% in others. As McKhann points out,[10] "the attack on lead poisoning in children must be made largely through prophylactic measures." Much has been accomplished through the abolition of the use of lead paints in the manufacture of children's toys and furniture; that this is not sufficient is attested by the fact that severe cases of plumbism continue to occur with disconcerting frequency. The two cases reported here were both discovered during the last six months and both occurred in Portland, indicating that the disease is not uncommon. It seems apparent that some alternative or additional prophylactic measures must be adopted if we are to be successful in combatting this disease.

To our knowledge, the prevention of lead poisoning through the treatment of the underlying nutritional anemia with consequent prevention or cure of pica has not been previously emphasized. The rationale of such an approach seems to be well established, now that the interrelationship of iron-deficiency with anemia, gastric achlorhydria, and pica has been established. The treatment of this iron-deficiency, or so-called "milk anemia" has been largely neglected in the past, in spite of the simplicity and unquestionable efficacy of oral iron therapy. It is our suggestion that prompt and adequate treatment of all cases of moderate or severe nutritional anemia, especially those in which pica has developed, may effectively reduce the incidence of lead poisoning in children by restoring the gastric acidity to normal and thus abolishing the pica.

Case # 1. L. O., a 25-month-old white female child, entered the M. G. H. on 4/21/46 with generalized convulsions. Family history was non-contributory. Past history revealed a normal pregnancy and neonatal course. The child's dietary history showed a distaste for green vegetables and a preponderance of milk foods in the diet. No supplemental iron had been given. Present illness began at the age of 1 year, at which time the parents had noted a moderate pallor of the child's skin. Her development had been rather slow: there were four teeth at 1 year, and the child did not walk until the age of 19 months. During the 5 months prior to admission the mother had noticed an abnormal appetite in the child, with frequent chewing of paint from the play-pen and furni-

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ture. For 4 months there had been occasional vomiting, with a progressive exacerbation during the month preceding admission. For approximately three weeks there had been marked anorexia, and the pallor had become extreme. Three days prior to admission the child developed a stiff neck and slight fever, and on the day of admission suddenly began to have left-sided tonic-clonic convulsions.

Physical examination on admission revealed a moderately well-developed and well-nourished white female child in continuous convulsions. Her skin and mucous membranes exhibited a marked pallor. The anterior fontanel and cranial sutures were closed. The head was turned to the right, and after the convulsions had been controlled with ether, the eyes showed a slow lateral nystagmus with the fast component to the left. The pupils were equal, dilated, and fixed. The ocular fundi appeared pale; there was no papilledema. The neck was stiff. The chest was clear to percussion and auscultation. The heart was enlarged to the anterior axillary line on the left; the rate was 150; there was a Grade III systolic murmur at the apex, transmitted over the whole precordium; a gallop rhythm was noted. The abdomen was soft, and the liver edge was 1 cm. below the costal margin on the right. The left arm and leg showed clonic convulsive movements, while the right arm and leg were flaccid; there was pronounced bilateral sustained ankle clonus.

Laboratory data: On admission, the Hb. was 4.5 grams, or 31%. Rbc: 3,100,000. Wbc: 21,500 with 54% polys, 40% lymphos, and 6% monos. The red cells showed many macrocytes but no stippling was seen. Cerebro-spinal fluid obtained on admission contained no cells, a normal amount of sugar, and 50 mgm. total protein. Repeated urinalyses were negative except for 20 mgm. albumin on one occasion, and a trace of sugar on another. Following her second transfusion, the hemoglobin had risen to 8.7 grams, or 60%, and the rbc was 3,870,000. At the time of discharge Hb. was 10.9 grams, or 75%, and the rbc was 4,920,000. A blood smear taken on the fourth hospital day showed occasional stipple cells. X-rays of the wrists and ankles were interpreted as follows: "There is an increase in density of the epiphyseal line of the radius and ulna and of the proximal epiphyses of the proximal phalanges consistent with the 'lead line' as seen in lead poisoning."

Course: The patient was kept in oxygen for two days. She received 300 c. c. whole blood shortly after admission, and another 300 c. c. on the following day. Her temperature, which was 104° on admission, fell to normal by the fourth hospital day. She was able to take fluids by the third day, and milk was forced to 1000 c.c. daily. The child was largely unresponsive to visual and auditory stimuli for several days, during which time the pupillary reflex returned. At no time was there any papilledema. By the 10th day she seemed brighter, and began to play with her toys, and by the time of discharge on the 28th day she seemed entirely normal. There were no mental, sensory, or motor residua in evidence. At the present time, three months later, she is apparently entirely well. Her Hb. at present is 86%, and she is gaining weight steadily. There has been no return of her abnormal appetite.

Case # 2. L. P., a 33-month-old white female child was admitted to the M. G. H. on 8/11/46. The mother stated that the child had been vomiting four or five times daily for two weeks. Past history is interesting in that this child had been bitten by a rat at the age of 7 months, and subsequently developed rat-bite fever, which was treated in this hospital with penicillin. Subsequently, she had been quite well except for several episodes of severe upper respiratory infections, which were also treated here. The most recent of these episodes had occurred three weeks prior to admission. Family history revealed frequent unexplained convulsions in a 4-year-old sibling. There were 7 brothers and sisters, all living in two rooms with the parents. Present illness began two weeks preceding admission, at which time the mother noted an unsteady gait, anorexia, irritability, and vomiting. On numerous occasions the child was observed to be chewing paint from window-sills, chewing the burnt ends of matches, and putting coins and other objects into her mouth. For 12 hours prior to admission the child had shown projectile vomiting.

Physical examination on admission revealed a moderately well-developed and well nourished

white female child who showed a marked pallor. There was no lymphadenopathy, EENT negative. No funduscopic examination was done at the time of admission. The neck was supple, and the chest was clear. The heart rate was 68, and there was marked sinus arrhythmia with frequent extra-systoles. There was a Grade III systolic murmur at the apex, and an early diastolic murmur at the apex. The abdomen was doughy, and the liver edge was palpated 2 finger-breadths below the costal margin on the right.

Laboratory data: On admission the Hb. was 7 grams, or 63%; rbc 3,200,000; wbc 10,200. Differential was 42% polys, 1 eosin, 1 baso, 49% lymphos, and 7% monos. There was a definite achromia, marked variation in size and shape of the red cells, marked polychromatophilia, and occasional stipple cells were seen. Spinal fluid contained no cells, normal sugar, and 150 mgm. total protein. Urine showed 10 mgm. albumen and a trace of sugar.

On the second day a blood smear showed definite variation in size and shape of the red cells, moderate achromia, and numerous stippled cells.

X-rays of the wrists and ankles showed "a dense line extending across the lower ends of the diaphyses of the radius, ulna, tibia, and fibula . . . probably a pathological line, as seen in lead poisoning."

Course: Shortly after admission, the child developed a generalized clonic convulsion, involving chiefly the left side. This was controlled with ether, and subsequent convulsions were controlled with ether, Luminal, or 25% Mag. Sulfate i.m. Fluids were given parenterally, and the child was placed in oxygen. By the end of 24 hours her condition was much improved. She was sitting up in bed, taking fluids well by mouth, and vomiting and convulsions had ceased. Her temperature, which was 99 on admission, had risen to 102 and then fallen to normal. At the end of the third day she was found dead in her bed, with no obvious cause. Autopsy permission was refused.

Summary

The relationship of pica to lead poisoning in children is discussed, and the possibility of preventing lead poisoning in children by treatment of the nutritional anemia, which is so frequently associated with the pica, is suggested. Two cases of lead poisoning are reported, of which one died and the other made an uneventful and apparently complete recovery. In each case the diagnosis was made tentatively on the basis of a history of pica, and confirmed by 1) the presence of vomiting, headache, stiff neck, or other symptoms of increased intracranial pressure, 2) the presence of a marked polychromatophilia with basophilic stippling of the red blood corpuscles in the peripheral blood, and 3) the presence of the typical "lead lines" at the ends of the long bones, by X-ray. In the first case there is evidence of a nutritional anemia of long standing, with pica developing as a relatively late symptom. In the second case the history of repeated severe infections may be significant, although there is no positive evidence that there was a pre-existing iron-deficiency anemia.

Conclusions

1) Two cases of lead poisoning in children due to pica are reported.

2) The importance of iron-deficiency anemia in causing pica is discussed.

3) The suggestion is made that early and adequate treatment of such anemia may, by eliminating pica, result in the prevention of similar cases.

References

1) Abbott and Ahmann: *Am. J. Dis. Child.*, 58:811-816 (1939).

2) Faber, et al.: *Jour. Ped.*, 7:435-451 (1935).

3) Fullerton: *Arch. Dis. in Child.*, 12:91-110 (1937).

4) Hawksley, et al.: *Ibid*, 9:359-372 (1934).

5) Hill: *N. E. J. Med.*, 201:261-265 (1929).

6) Josephs: *Medicine*, 15:307-451 (1936).

7) Josephs: *Bull.*, J. Hop. Hosp., 51:185-209 (1932).

8) Mackay and Goodfellow: Med. Reas. Council, Special Report Series, No. 157 (1931).

9) Stewart: *Brit. J. of Child. Dis.*, 34:1-27 (1937).

10) McKhann: Brenneman's "Practice of Pediatrics."

11) Blackfan, Diamond, and Leister: "Atlas of the Blood in Children" (1944).

What Is the Association of American Physicians and Surgeons (A. A. P. S.)?

Lloyd H. Berrie, M. D., Caribou, Maine

The Association of American Physicians and Surgeons was organized over two years ago by the members of the Lake County Medical Society (Gary and Hammond, Indiana) after a unanimous vote of its 253 members. At the present time, membership includes physicians in every state and 851 County Medical Societies. All members must belong to the A M. A.

THE A. A. P. S. OBJECTIVES ARE:

1) Accomplish the universal application of the insurance principle to the costs of medical care under proper voluntary plans.

2) Educate the people to use and benefit from voluntary plans of prepayment sickness insurance.

3) Organize physicians so that they may determine and enforce the conditions under which they will or will not give their services.

4) Operate an endless public relations program which, first, will correct any errors within the profession, and then, use every available publicity channel to tell the public what has been accomplished in its interest.

5) Conduct a continuing publicity campaign to inform all levels of the Public of the evils of compulsory health insurance and state or socialized medicine.

6) Earn again the respect for and understanding of the medical profession by the nation's lawmakers through proper, effective representation in Washington.

7) Effect increasing support of the American Medical Association so that this scientific body may continue to improve upon its contributions to public health and the science of medicine.

The AAPS pledges its members to retain the present system of free and independent enterprise in American medicine should the Wagner-Murray-Dingell bill pass the legislature, or should some similar scheme be foisted upon the American Public. Such action is not unconstitutional nor illegal. It is proposed because they refuse to give up our heritage as free men and because of the knowledge that governmental control of medical practice has always resulted in tragic deterioration in medical efficiency wherever it has been imposed upon the people.

The following information, in quote, is from personal communications by Harold T. Law, M. D., president, AAPS:

"Our Association is supported by the direct memberships (signed membership application) of physicians who pay this Association $10.00 per year for the privilege of their membership. As a consequence, we represent physicians authoritatively and have the right to regulate practices within the profession by majority consent of our membership.

The National Physicians Committee (NPC) is supported by contributions from most of the large pharmaceutical companies and some physicians. Therefore, they cannot officially represent the medical profession, even though their platform undoubtedly has the support of the majority of the profession; and they do not have the power to regulate practices within the profession.

I think you will agree that the main reason American medicine finds itself in the precarious condition it is in today, is because of the weak and ineffectual public relations program. In the science of medicine, our position is preeminent in the world. We doctors have been so busy doing the proper job of providing the best medical care for our patients that we, and our associations, have failed to keep the public informed as to what we have accomplished in their interest. It is obvious, therefore, that one of our most important tasks is the accomplishment of an effective public relations program.

Public relations, as interpreted by the experts in this field, does not constitute mere publicity

or propaganda. Publicity and propaganda are only some of the tools of a public relations program. If we are to perform a true job of public relations, we must first correct mistakes within the profession, and then use the mediums of publicity and propaganda to tell the public what we have accomplished in their interest. In order to do this, organizations must have the same power as county medical societies now have, the power to regulate by majority consent.

In other words, our Association is so organized that it can perform an effective public relations job for American medicine. The NPC cannot do this. The NPC can only operate as a publicity or propaganda bureau, and in our opinion, we believe that they have accomplished some good with their publicity and propaganda. That is why this Association, from the time of its inception, has constantly urged continuing support of the NPC.

This Association differs from the AMA because, in the past, most of the AMA activities have been devoted to the fields of public health and the science of medicine; whereas our program of objectives are devoted exclusively to medical economics, public relations and legislation.

I certainly concur with your statement that American medicine must present a united front against powerful and well-organized influences who propose to regiment us and our patients. Since the inception of this organization, we have continued to extend a coöperating hand to the AMA and the NPC. It is our belief that American medicine needs all three groups. Our work is in different fields, and frankly, I believe we stimulate each other to greater and more effective representation of American physicians."

With the exception of Dr. Fishbein, the officials of the AMA have silently approved our activities, and we have enjoyed friendly relations with them. This was quite evident when we appeared in Washington at the hearings on the Wagner-Murray-Dingell bill, as for several days we were in constant association with AMA representatives, who also appeared before the Committee.

"After my experience in Washington, and first-hand contacts with the powerful groups who are determined to regiment medicine for the purpose of using it as an entering wedge to stifle free enterprise and accomplish eventual over-all socialized economy for this country, I am convinced of two things: first, the AAPS plan of non-participation offers the only immediate permanent solution for American medicine to resist regimentation; and second, I concur with the *Rocky Mountain Medical Journal* editorial that American medicine is not "over organized," in fact, I do not believe it can be over organized, as long as our respective organizations are united in their ethics and their objectives.

I believe that you will agree with me that if we physicians had to belong to ten medical groups, and pay membership fees to all of them, and by doing so we are successful in providing the best medical care for our patients, it would be a small price to pay.

You may be sure that this Association is not attempting to "get away with something illegal." The Lake County physicians spent more than $5,000 in having attorneys in various states in the Union, test the legality of the AAPS plan of non-participation, if and when political medicine became the law of the land.

As you probably know, President Truman, on November 19, publicly declared that physicians had the right to refuse to participate in political medicine. If you have followed the *AMA Journal* reports of the hearings held in Washington on the Wagner-Murray-Dingell bill, you will have noted that a number of Senators, as well as witnesses appearing before the Committee, have admitted the right of physicians to refuse to participate.

We believe that the American Medical profession has done a very poor job in informing the people of what American medicine has accomplished in their behalf. We have failed to enlighten them as to the evils which follow in the wake of political medicine, as indicated by the experiences in foreign countries which have tried these schemes. I know that you will agree that as true physicians, our first urgent moral responsibility is to the welfare of our patients. Since the American public has been deliberately misinformed by the socialist groups, who are trying to force compulsory insurance upon

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The President's Page

Should we be pleased because the Wagner-Murray-Dingell Bill has not passed, and do nothing about any kind of medical plans?

I know there are many in our Society who believe that the country is saved so far as any form of planning for people of the low income group is concerned.

Let's not forget that there are many people who are complaining more than ever at the cost of being sick, and the number of them is increasing.

During the time when it looked as if we might be taken over by the State, our slogan was,—"A Society as great as the A. M. A., which has done more for the people of the U. S. A. than any other single body of individuals, should be able to evolve some effective and satisfactory plan for the people of low income group to form a budget to take care of their sickness."

We believe that the Medical Profession is capable of, and is the organization to look after that very thing.

Let's not go to sleep, but be on the alert to put over some plan whereby these people may be well taken care of.

It seems rather appalling that we can be indifferent to this state of affairs, for there are certain conditions in the various communities of our country, which if not remedied, will take many generations to overcome.

The things are directly traceable to the cost of medical care, and of everything we deem so necessary today.

Again, I say, let's keep busy on this question, and solve it before it is solved for us.

John O. Piper, M. D.,
President, Maine Medical Association.

Editorial

The Fall Clinical Session

The one hundred and eight physicians registered at the Fall Clinical Session held in Bangor, Maine, December 1 and 2, 1946, will, I think, agree that it was a meeting well worth attending, and that the registration was good considering what the weather had to offer.

The session was sponsored by the Penobscot County Medical Association with Dr. Edward L. Herlihy, Chairman, and Dr. Forrest B. Ames, Secretary, of the Committee on Arrangements. The members of the Association, and their wives, certainly proved themselves to be excellent hosts and hostesses.

The social hour at 6.00 P. M., Sunday, December 1st, at the Bangor House, official opening of the session, was a gala event, and gave to the occasion a holiday air — which was what was intended for that part of the program. Professor Herschel L. Bricker, Professor of Speech at the University of Maine, who has recently returned from a tour of Europe, related his experiences in a somewhat informal address entitled "Theatre in the European Theatre."

The clinical sessions on Monday, December 2nd, at the Eastern Maine General Hospital, the Bangor Sanatorium, and the Bangor State Hospital, were well attended in spite of hazardous traveling.

Monday evening, at 6.00 P. M., found those present again gathered at the Bangor House for the evening program. Guest speakers were Dr. Chester S. Keefer, of the Evans Memorial Hospital, Boston, who spoke on "The Use of Antibiotics in Medicine," and Dr. Ralph Adams, of the Lahey Clinic, Boston, whose subject was "Surgery of the Esophagus."

It was a day and evening of Scientific Programs, offering and giving to those privileged to attend a great deal of value.

This is the first Clinical Session to be held since 1941, and it is hoped that the sessions will become once again an annual event for the members of the Maine Medical Association to look forward to.

Progress Toward a Medical School

There is no further need in this report of going into the pros and cons of the need of a medical school in the State of Maine to work in conjunction with the Public Health Service of the State.

A Committee was appointed by John O. Piper, M. D., President of the Maine Medical Association, at the June, 1946, meeting of that group. This Committee consisted of Leverett D. Bristol, M. D., Frederick T. Hill, M. D., Harvey C. Bundy, M. D., Stephen A. Cobb, M. D., Eugene H. Drake, M. D., Eugene E. O'Donnell, M. D., Clyde I. Swett, M. D., Wallace E. Webber, M. D., Adam P. Leighton, M. D., and the writer, and was later supplemented by the addition of Carl H. Stevens, M. D., George E. Young, M. D., and Samuel R. Webber, M. D. This gave us broad geographical coverage so that we could educate the public in all parts of the State and could have the Senators and Representatives contacted by doctors in their own localities.

Many civic groups were contacted, including the state meetings of the Grange. All reactions were favorable.

At this point, we are fortunate in having W. Mayo Payson, who was appointed Executive Secretary for the State Association as a consultant and helper. Mr. Payson has had a great deal of experience, not only with his own legal

line but also as a member of the State Legislature. His advice has been invaluable.

A bill will be presented to the State Legislature. Anyone who has kept at all informed on State affairs will know that the big item facing this Legislature is that of expense. The main points of the bill will consist of:—

1. Authorization of a medical school;
2. Creation of a Building Commission for it; and
3. An appropriation of one million dollars to build and equip the buildings.

The Building Commission will have complete charge until the buildings are completed, at which time they are to be turned over to the sole control of the Trustees of the University of Maine. All of this would be coupled with the understanding that the Trustees are under no obligation to start operation of a medical school until due appropriation is made to take care of the budget of the school. It has been understood from the beginning that there has been no room for us at the University of Maine as the buildings stand at the present time. Furthermore, that we will not at any time or in any sense expect any financial backing from the University as it is now represented. This, of course, is due to the fact that the University is under a tremendous expense at present, as you all know. We must stand on our own two feet.

All legislators in the State have been contacted, either personally or by written information. We would appreciate it very much if every member of the Maine Medical Association would do everything in his power with his local public and with the Legislators from his region to further the project of the medical school in Maine. This is no longer a localized project; it is statewide and even has the approval of the Council of Medical Education at Chicago. Let's get behind it as an Association!

Edward L. Herlihy, M. D.,
Chairman of the Committee for the Reopening of a Medical School in Maine.

Medical Group Told Socialized Program Ended

The last election eliminated any immediate threat of socialized medicine in America, Governor Green (of Illinois) told a meeting of the American Medical Association held December 8th, 1946, but it is now up to the medical profession to spearhead a drive that will fill present gaps in medical care for the people.

Governor Green, who addressed the state secretaries and editors of the American Medical Association in their headquarters, in Chicago, said the ten-point national health program sponsored by the association will meet the needs of the people and should be pushed with vigor.

"It is natural that in a period when various collectivist philosophies were sweeping the world, proposals for some form of state medicine or socialized medicine should take hold with many people," the governor said. "Those proposals have been particularly alluring to many laymen because they have been offered in connection with other sound health measures which have your support . . .

"I believe that, fortunately for your profession and the people, both have been saved from any immediate danger of a medical bureaucracy," he continued. "With some pride I suggest that that successful operation was performed by the politicians and the people.

"In all truth the national election last month was essentially a referendum on the issue of federal bureaucratic controls versus private enterprise. The verdict was so strongly for private enterprise that I'm sure you will find little disposition in the next congress of the United States to proceed further with socialistic experiments.

"I believe the election has eliminated the possibility of any present enactment of the portions of the Truman health program which the medical association regarded as a real threat to private enterprise and scientific progress."

The ten-point health program of the association provides among other things for minimum standards of nutrition and housing, encouragement of non-profit prepayment plans for hospitalization and medical care and preventive medical services through health departments.

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County Society Notes

Cumberland

A meeting of the Cumberland County Medical Society was held at the Maine Eye and Ear Infirmary, Portland, Maine, on Friday, December 20, 1946, with Dr. Elton R. Blaisdell, presiding. An excellent dinner was served in the nurses' dining room at 6.30 P. M., and the meeting began at approximately 8.00 P. M. Following the reading of the annual report of the Secretary-Treasurer, the following members were elected Officers of the Society for 1947:

President, Dr. Edward A. Greco, Portland.

Vice President, Dr. Nessib S. Kupelian, Pownal.

Secretary-Treasurer, Dr. Joseph E. Porter, Portland.

Delegates to the Maine Medical Association for two years: Dr. Oscar R. Johnson, Portland; Dr. Maurice J. Dionne, Brunswick; Dr. James M. Parker, Portland; and Dr. Ervin A. Center, Steep Falls. Alternate for one year: Dr. Eaton S. Lothrop, Portland. Alternates for two years: Dr. Kenneth E. Dore, Fryeburg; Dr. Louis A. Asali, Portland; Dr. Carl E. Dunham, Portland; and Dr. Harry E. Davis, Portland.

Legislative Committee: Dr. Thomas A. Foster, and Dr. Harold V. Bickmore.

Public Relations Committee: Dr. William Holt, and Dr. Eugene E. O'Donnell.

The principal speaker of the evening was Dr. John O. Piper, of Waterville, President of the Maine Medical Association, who chose as his subject "The Changing Order in Medicine." He outlined the general changing trends in economic life throughout the country, and pointed out significant improvements in medical care as observed in World War II. As evidence, he stated that in World War I, 24% of the soldiers who developed pneumonia died, while in World War II less than 5% died. Chest wounds were fatal to 70% of the men who received them in World War I, while in World War II only 20% died of such wounds. He pointed out that it is the desire of organized medicine to deliver a very high quality of medical service. The medical profession favors the extension of medical services in the form of hospitals and diagnostic and health centers, but he quoted the American Medical Association as saying that it does not favor compulsory medical insurance.

The medical staff of the hospital presented a clinic at 5.00 P. M.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

The annual meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Wednesday evening, December 11, 1946, at 6.30 P. M.

The meeting was called to order by President Weymouth who complimented the members of the society for the good attendance at this meeting, and said that he hoped to be able to greet some of the dues-paying, non-attending members of the society at a future meeting.

It was moved and seconded that the present officers, whose names follow, serve for the ensuing year, and the motion passed by the society.

President, Dr. Raymond E. Weymouth, Bar Harbor.

Vice President, Dr. Arthur H. Parcher, Ellsworth.

Secretary-Treasurer, Dr. James H. Crowe, Ellsworth.

Delegate to the Maine Medical Association: Dr. Crowe. Alternate: Dr. Philip L. Gray, South Brooksville.

Censors: Drs. Edward Thegan, Raymond W. Clarke, and Dwight Cameron.

Dr. Norman E. Cobb, of Calais, Councilor for the Fifth District, was a guest of the society, and spoke about problems coming before the State Association Council.

Dr. Frederick T. Hill, of Waterville, presented a paper on "Atelectasis," which was followed by a period of general discussion.

J. H. Crowe, M. D.,
Secretary.

Knox

The annual meeting of the Knox County Medical Society was held at the Copper Kettle, Rockland, Maine, December 12, 1946.

The following Officers were elected for 1947:

President, Dr. Wesley N. Wasgatt, Rockland.

Vice President, Dr. Frederick C. Dennison, Thomaston.

Secretary-Treasurer, Dr. Freeman F. Brown, Jr., Rockland.

It was voted to make Dr. Alvin W. Foss, of Rockland, an Honorary Member of the Knox County Society.

Freeman F. Brown, Jr., M. D.,
Secretary.

Lincoln-Sagadahoc

A regular meeting of the Lincoln-Sagadahoc County Medical Society was held at the Hotel Sedgwick, Bath, Maine, on Tuesday, December 10, 1946.

A symposium on Head Injuries was presented by Dr. George F. Maltby of Portland, Dr. Warren E. Kershner, of Bath, and Dr. Harry M. Wilson, of Bath. An interesting general discussion followed.

Virginia Clay Hamilton, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Society was held at the Milo Hotel, Milo, Maine, December 12, 1946, at 4.00 P. M.

Dr. Howard C. Pritham, of Greenville Junction, was elected to membership in the Society.

Dr. Martin A. Vickers, of Bangor, spoke on "Allergy." He spoke without notes and permitted many interruptions, thus making a rather informal discussion. It was a very instructive meeting.

Ten of the seventeen members were present, all of whom paid their dues for 1947.

At 5.30, a steak dinner was enjoyed, after which the meeting was adjourned.

N. H. Nickerson, M. D.,
Secretary.

New Members

Androscoggin

Geraldine Lynn, M. D., Lewiston, Maine.

Cumberland

Albert A. Darche, M. D., Westbrook, Maine.

Piscataquis

Howard C. Pritham, M. D., Greenville Junction, Maine.

100% Paid Membership for 1947
Piscataquis County Medical Society

*Blood Transfusion and Transfusion Reactions—**Continued from page 9*

5. DeGowin, E. L., Warner, E. D., and Randall, W. L.: *Arch. Int. Med.* 61:609, 1938.
6. Seligman, A. M., Frank, H. A., and Fine, Jacob: Treatment of Experimental uremia by means of peritoneal irrigation. *J. Clin. Invest.,* 25:211, 1946.
7. Neefe, J. R., Gellis, S. S., and Stokes, Joseph, Jr.: Homologous Serum Hepatitis and Infections (Epidermic) Hepatitis. *Am. J. Med.,* 1:3, 1946.
8. Witebsky, E., Klendshoj, N. C., and Swanson, P.: Blood substitutes and blood transfusion. Springfield, Illinois, Charles C. Thomas, 1942, P. 327.
9. Levine, Philip, and Waller, R. K.: Erythroblastosis Fetalis in the Firstborn. *Blood,* 1:143, 1946.

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News and Notices

Thomas A. Martin, M. D., of Portland, was appointed Chief of Orthopedic Service in the Maine General Hospital at a meeting of the Board of Directors held December 4, 1946.

Philip H. McCrum, M. D., of Portland, was appointed Chief of Obstetrical Service in the Maine General Hospital at a meeting of the Board of Directors held December 4, 1946.

Roscoe L. Mitchell, M. D., of Augusta, Maine State Health Director, recently was elected Vice President and an Executive Member of the U. S. Association of State and Territorial Health Officers.

Carl M. Robinson, M. D., of Portland, was elected to the Board of Governors of the American College of Surgeons at a meeting held in Cleveland, December 19, 1946.

George A. Tibbetts, M. D., of Portland, was elevated to the Honor Staff of the Maine General Hospital at a recent meeting of the Board of Directors. Dr. Tibbetts will serve the hospital in a consulting capacity while continuing his private practice.

The Eye-Bank For Sight Restoration, Inc.

The Board of Directors of The Eye-Bank for Sight Restoration, Inc., following a meeting held December 6, 1946, announced the following Scholarship and Fellowship awards and appointments:

Dr. Herbert M. Katzin, of New York, has been put in charge of the Laboratory for Ophthalmic Research of The Eye-Bank for Sight Restoration, Inc.

Dr. Frank Constantine has been granted a Fellowship to pursue studies in relation to corneal vascularization.

Dr. Arnold Forest of the Army Institute of Pathology, Washington, D. C., has been granted a Fellowship for training in Ophthalmic Pathology with special emphasis on corneal pathology.

Dr. Milo H. Fritz, of New York, has been granted a Fellowship to continue studies in vitreous replacement and vitreous transplants.

National Conference on Medical Service

The 20th Annual Meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, Illinois, on February 9. Registration will commence at 9.00 A. M. and the program will include discussions in the fields of national affairs, economics and medical education. All physicians are invited to attend, there is no registration fee. Dr. Cleon A. Nafe, Indianapolis, is President of the Conference and Creighton Barker, New Haven, is the Secretary.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.



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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

What Is the Association of American Physicians and Surgeons?—Continued from page 14

them, as physicians, we must refuse to participate in schemes of political medicine because it is our duty to our patients, as well as to ourselves and our profession — at least, until we have had time to enlighten the American public."

Doctor Low's statement made before the Senate Committee on Education and Labor, April 18, 1946, was, in this writer's opinion, the most precise, factual and damaging testimony that has been heard thus far against the W. M. D. bill.

In an editorial published in this JOURNAL a few months ago, an outline was presented, showing that the strategy of the proponents for compulsory health insurance, which is the entering wedge for state government or totalitarianism plans for this country, and the world, would be an attack directed against the medical profession. This attack is gaining in intensity.

To anyone who has read the abstracts of the hearings on the W. M. D. Bill, it should be increasingly evident that something is quite apt to be done to bring our profession under governmental and lay control, totally, or in part.

It is also clearly apparent that the forces behind this plan are multiple and large, and that they are well organized. That their statements and statistics are tricky, their propaganda false, and their methods often shady, does not for a moment decrease the effectiveness in influencing a gullible public.

The issue is quiescent just now in Washington. This is, however, no time for complacency among us. The evil forces who thirst for power are working and planning new schemes that will accomplish their end. They have the blessings of Labor and the Chief Executive.

As an example witness Public Law 601, passed during the closing days of the 79th Congress. It provides that any person who directly or indirectly attempts to influence Legislation must register with the Clerk of the House of Representatives, file quarterly statements to be published in The Congressional Record. Exempt are political committees—(PAC, for instance) — State and Local, any public official acting in his official capacity, newspapers and publications. Penalties of one year in jail and a $5,000 fine are provided. The bureaucrats are exempt. They can propagandize limitlessly! This is now a law despite the recent political swing! Perhaps the AAPS has the only defense.

We give our medical students innumerable facts from which they should infer that the periodic health examination is important. Yet, partly because we do not carry this education through to its behavior aspects as related to them, physicians themselves seldom have such examinations. They are more likely than most people to develop active tuberculosis, and have little advantage over others in recognizing an early case in themselves. Yet how few have periodic X-rays. Those who smile self-righteously at the physicians might reflect, however, that the failing is common elsewhere. Some time ago, the Minnesota Supreme Court, in handing down an opinion, remarked that lawyers, although recognizing the dangers common when no will has been made, notoriously seldom have made wills themselves.—Carl J. Potthoff, M. D., *Amer. Jour. P. H.*, Oct., 1945.

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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, February, 1947 No. 2

Abortifacient Action of Penicillin in Pregnancy

Robert C. Rainie, M. D., and Milan A. Chapin, M. D.

From the Department of Medicine, Central Maine General Hospital, Lewiston, Maine

Although cases of actual and threatened abortion complicating the administration of penicillin in pregnancy have been reported in the literature,[1, 2, 4] this effect of penicillin is denied by others.[3, 5] Since this drug is still in its investigative stage, it is essential that the profession be advised of any untoward effects from its use. It is with this idea in mind that we wish to report the following four cases of actual or threatened abortion which have occurred during the administration of penicillin to six pregnant women.

Case Reports

Case 1. M. N., a 32-year-old white divorcee, approximately 7 months' pregnant, was found to have positive serologic tests for syphilis at the time of admission to the hospital. She appeared to be in early false labor and the membrane had ruptured. There was, however, no appreciable dilatation of the cervix and the fetal head was not engaged. There was no pain or other evidence of early labor during the first three hospital days. For treatment of the serologic syphilis, 50,000 units of penicillin were administered intramuscularly every three hours. After having received six injections there was onset of low abdominal cramps which were interpreted as mild uterine contractions. There was no vaginal bleeding and the cervix did not dilate. The low abdominal cramps continued for 16 hours, disappearing without recurrence during the remainder of the uninterrupted course of penicillin administration.

Case 2. F. B., a 22-year-old white married female was admitted with serologic syphilis during the fourth month of pregnancy. After receiving a total of 1,000,000 units of penicillin in doses of 50,000 units intramuscularly every three hours, low abdominal cramps and uterine contractions developed. These lasted for 12 hours and subsided without recurrence. Penicillin administration was uninterrupted.

Case 3. L. C., a 15-year-old white married female, approximately 8 months' pregnant, was referred to the hospital for treatment of early syphilis. After penicillin had been administered intramuscularly in doses of 50,000 units every three hours for a total of 1,500,000 units,

uterine contractions developed, followed by vaginal bleeding and dilatation of the cervix. After several hours of heavy labor, the patient was delivered of an apparently normal male infant with the cord blood giving a positive serologic reaction.

Case 4. H. C., a 28-year-old white married mother of two children was admitted for treatment of bronchiectasis of the right middle and left lower lobes. There was a coexisting pregnancy of approximately 5 months. There had been no abdominal cramps prior to her admission to the hospital, her course of gestation had been uneventful and her cough was quite well controlled. Penicillin inhalations of 20,000 units every three hours was administered. After a total of 180,000 units had been given over a period of 36 hours, the patient began to have low abdominal cramps and uterine contractions followed by vaginal bleeding. Penicillin, 40,000 units intramuscularly every three hours, was then substituted for the inhalations. The abdominal pains continued throughout the night with increasing severity in spite of sedation, and the following morning a complete miscarriage occurred, 48 hours after penicillin was first administered.

Two other cases of early syphilis with coexisting pregnancy have been treated with similar courses of penicillin without complication.

Comment

The possible abortifacient action of penicillin when administered to pregnant women has been noted in recent reports. In 1944, Ingraham, Lentz, Beerman and Stokes,[1] in treating 14 pregnant women with early syphilis, recorded two cases of threatened abortion as evidenced by vaginal bleeding and low abdominal cramps after 18 and 48 hours, respectively, of penicillin therapy. When administration of the drug was discontinued for 24 hours and then readministered for completion of the course of therapy, no recurrence of symptoms was noted. This effect was interpreted as a form of therapeutic shock—a Jarisch-Herxheimer reaction. It was felt that, in such circumstances, a reduction in the amount of penicillin administered during the first 36 to 48 hours was indicated.

In a more recent paper,[2] Ingraham, Stokes, Beerman, Lentz and Wammock have reported the treatment of 49 pregnant women with penicillin. In most instances, the amount of penicillin administered during the first 48 hours was reduced to one-quarter of the usual amount. In spite of this caution, reaction to the therapy in the form of threatened abortion was noted in 5 patients, two of whom progressed to complete abortion. Milder forms of lower abdominal discomfort were noted as not uncommon during the first 24 to 48 hours, often accompanied by a febrile Herxheimer reaction. These authors, therefore, concluded that the possibility of abortion is a very real threat to some pregnant syphilitic women treated with penicillin.

Leavitt[4] observed 2 actual and 6 threatened abortions among 21 pregnant women with syphilis who were treated with penicillin. Since 7 of the total of 8 patients manifesting this reaction were treated with the same lot of penicillin, this suggested that either the penicillin or some impurity in the commercial preparation exerted a stimulating effect on the contractility of the uterine musculature. This explanation justifies consideration in view of the fact that penicillin is a product of mold growth and theoretically, therefore, in the same category as ergot.

On the other hand, Goodwin and Moore[3] and Speiser and Thomas,[5] in their combined series of 180 pregnant women with syphilis who were treated with penicillin, observed no reaction in the form of actual or threatened abortion. Goodwin and Moore believe the suggestion that penicillin has abortifacient effects to be unwarranted by the facts.

If one combines the total of 90 patients treated by Ingraham and his group, Leavitt and ourselves, there were 6 actual and 13 threatened abortions. This effect, occurring in approximately 21 percent of the total treated cases, would appear significant. It is difficult to understand why this complication should have been observed by three different groups, whereas, in two others comprising a larger combined series, it has not been noted. This being so, the possibility exists that differences in various commercial preparations of the drug, perhaps in the form of uterus-stimulating impurities, may explain these divergent findings in different clinics.

Continued on page 48

*Abdominal-Perineal Wounds**

M. Tieche Shelton, M. D., Augusta, Maine

The subject of lower abdominal wounds and wounds involving the perineum and associated structures continues to interest every practicing physician be he either surgeon or general practitioner. The large number of these injuries treated in the recent World War II necessarily added to the store of knowledge concerning these cases, but there is still much to be learned. This paper is merely a condensed report based on my personal observations and experiences in treating this type of injury in Field and Evacuation Hospitals during World War II. Of necessity, this work was performed in tents for the most part and therefore not in ideal surroundings. Also the periods of observation of individual patients rarely exceeded two weeks. Our duty consisted of saving life and preparing patients for evacuation to general hospitals in the rear zones. Every patient received definitive surgery before being evacuated from the hospital. However, the basic fundamentals remained the same everywhere, only the conditions differed, and for that reason I feel that the experiences gained from treating large numbers of injured men in the war will aid in the future treatment of patients in civilian life. The accidents here at home, no doubt will continue to keep the doctors well occupied in the future.

Character of Wounds

The various types of wounds encountered can be grouped simply as follows:

1. Penetrating
2. Perforating
3. Lacerating
4. Contusing

The missiles causing the wounds varied from small round bodies, such as rifle bullets to large shell fragments. All shell fragments were irregular and varied greatly in size. Naturally, wounds from shell fragments predominated in all theatres of operations. The types of missiles was very important from the standpoint of damage to tissue, as one can readily visualize, the smooth missile did much less damage than an irregular body passing through tissue. The irregular fragments produced large gaping wounds and eviseration more common in these cases. Usually the wounds were multiple, rarely single, and produced multiple injuries in other parts of the body besides the abdomen and pelvis. However, as a rule wounds involving the abdominal contents or bladder were considered to have priority number one with chest and brain next in order.

Pre-Operative Care of Patients

On admission every frank or suspected intra-abdominal injury case was placed immediately on routine shock treatment, that is, careful charting of pulse, respiration, blood pressure and always a definite note on the general appearance of the patient. About 50% of the seriously injured patients were in condition of shock on admission but everyone was considered a potential shock subject. Plasma infusion was immediately started and matching for blood transfusion initiated. A careful physical examination was made and special note made of the wound of entrance and exit, and the course of the missile with reference to the possible visceral organs or structures in the path of the foreign body. It never ceased to cause embarrassment to surgeons to discover an exit wound at the end of the operation. It was found to be extremely important to do rectal examinations and to obtain a specimen of urine, even if necessary by catheterization in wounds of the upper thigh, perineum, and lower abdomen. The presence of blood on the examining finger or blood in the urine give positive evidence of severe damage and a definite lead in treatment. After giving sufficient plasma, blood and supportive treatment, X-rays were taken if the condition of the patient permitted. In some instances the operation was performed without the advantage of X-rays

* Presented at the 92nd Annual Session of the Maine Medical Association, at Poland Spring, June 25, 1946.

because it was felt that the risk in moving the patient was too great. In this regard, many patients were operated upon without removing them from the litter in order to avoid the shock of handling. It became quite evident at an early date that the less the patient was moved or disturbed the better and it might mean the difference between a fair risk and a poor one.

Operation

The interval between injury and operation varied greatly, but in most instances, only a few hours elapsed between injury and operation as we operated near the front. The type of treatment remained the same regardless of the lapse of time. The watch and wait or expectancy treatment for any cause gradually disappeared because of the extremely high mortality. This is especially true of wounds of the lower abdomen and concurrent perineal wounds.

The optimum time for any operation is a vital factor and upon this decision may depend in many cases the difference between success and failure. The most reliable criteria is the general improvement of the patient manifest by a gradual rising blood pressure, slowing pulse and general alertness. The laboratory findings such as hematocrit index, blood counts, hemoglobin, etc., give valuable information for determining the fluid needs and are very essential in intelligent post-operative care. In many instances if the large blood vessels are injured, the blood pressure may fail to rise, fluctuate markedly or fail to rise more than 100 mm. mercury. Once the blood pressure reaches a maximum gain and then begins to fall recurrent shock may set in and a second improvement extremely difficult to obtain, sometimes impossible to bring the patient out of shock for the second time. Operating on a patient in which the blood pressure is rising usually gives good results.

All abdominal operations were performed under endo-tracheal anaesthesia using oxygen, nitrous oxide and ether. Frequently in good risks sodium penthotal was utilized to speed the induction of the anaesthesia. The results with endo-tracheal anaesthesia were very satisfactory and it gave complete relaxation, adding immeasurably to the success of the operations. Spinal anaesthesia could not be used because of the shocked condition of the patients and the ever present danger of shock. The contra-indication to this type of anaesthesia does not exist in the elective surgery of either civilian or war practice.

The skin area selected for the operation is prepared in the usual manner, first shaved carefully and then prepared with soap, water, ether, and merthiolate, or a similar preparation. The incisions were made in the usual manner except large incisions were the rule and if possible placed at some distance from the wounds of entry or exit. Wounds of entrance and exit are never incorporated in the exploratory incision if possible to avoid them. In wounds of the buttocks, perineum, and back, it is desirable to perform debridement prior to exploring the abdomen if the condition of the patient will allow the operation. When the patient is turned on face after having major abdominal work performed there is a very definite danger of inducing deep shock. All other wounds not requiring turning patient are debried following the completion of the major procedures. All wounds of the upper thigh, perineum, and back causes one to be concerned as to probable injury to bladder and lower abdominal contents.

It is imperative that all exploratory incisions are large, giving ample exposure for visualization of the structures to be examined. Especially is this true in the small perforating and penetrating wounds and at times it is impossible to find the point of injury except by direct vision. One cannot help but be amazed at times with the number of structures that may be injured by a fragment of steel traveling through the lower abdomen. Also, in most cases it is necessary to explore the upper abdomen, especially the small intestines, spleen and kidneys. In this regard it is necessary to always remember that one must not become so engrossed in a major wound of one organ and fail to investigate for additional injuries. Another point to remember is that an entrance and exit wound must be present in a hollow organ unless the missile can be found in the lumen of the organ. It is baffling at times to locate a perforation in the intestine that is between the leaves of the mesentery or, in case of the large bowel, behind the peritoneal attach-

ment. At any rate every hole in the bowel must be closed or the outcome in most cases will be fatal.

All perforations of the stomach and small intestines were closed by simple suture unless the damage was so extensive that simple closure produced kinking or encroachment on the lumen of the bowel. In the extensive lacerating and multiple wounds of the small intestines it was necessary to do resections and end-to-end anastamosis usually performed. The small bowel was never exteriorized. Distension and deflation of the bowel was well controlled by the use of an indwelling Levine tube with constant suction maintained with the aid of a Wagensteen apparatus.

The treatment of the large bowel including the sigmoid and rectum went through a gradual evolution or change until a definite routine was developed. During the early years of the war every surgeon used his own judgment and untilized his own pet ideas, the results both immediate and late were universally poor. Finally, the following methods of treatment for injuries of the large bowel were employed. Single or multiple perforations in a local segment required exteriorization of the area with an ample opening in the loop as a single colostomy. In case the damaged segment of bowel could not be exteriorized, the perforation or, perforations were carefully sutured and a loop of bowel proximal to the damaged segment was exteriorized and completely transected producing a complete diversion of the fecal stream. The colostomy performed in this manner was usually immediately opened if the operator desired, a clamp only left in place on the distal or lower loop. The colostomy was always made through a separate incision and never through the exploratory incision. Damaged spleens were removed. Also severely damaged kidneys required a nephrectomy. The exploratory incisions of the abdomen were closed in layers as a clean incision. At the end of the operation and not before, the wounds of entrance and exit were thoroughly debried and peritoneum and fascia closed, the only exceptions were posterior wounds that required turning the patient in order to do a debridment. Following debridment of these wounds, loose vaseline gauze to cover all raw surfaces and fill cavities was employed but the open wounds were never tightly packed with gauze.

The wounds of the rectum are extremely dangerous and carry a rather high mortality rate. In perforations of the rectal wall unless confined to or near the anus it is imperative to divert the fecal stream by performing a proximal colostomy. Again let me stress the point that in order to completely divert the fecal stream it is necessary to do a complete division of the bowel above the damaged area. A simple colostomy will not suffice in these cases. The complete division of the bowel in cases in which it is desirable to be certain that no fecal matter passes the damaged area may appear radical, however the later closure of any colostomy is a major procedure and in many cases an end to end repair is the preferred procedure with lower mortality, morbidity and better functional success.

In perforations of the bladder wall, an ample incision was made and suture of the defects performed under direct vision whenever possible. A cystotomy tube placed high in apex of bladder and suitable drains placed in the anterior and posterior vesical spaces. Ureteral repairs and transplants gave poor results in most instances.

The subject of drains is important enough to warrant a separate discussion but this paper would not be complete without mentioning a few salient facts about this matter. In the early days of the war it was not unusual to observe numerous drains extending from incisions and from separate incisions, following repair of wounds in the abdominal cavity. Gradually fewer drains were inserted until one rarely utilized abdominal drains following repair of the visceral damage. Drains were never placed in proximity to suture lines in repair of the intestines. At times it was necessary to pack for uncontrollable bleeding but this indication arose very rarely. The rule of no drainage of the peritoneal cavity has two definite exceptions. It is an absolute must to drain cases of liver damage where there is a likelihood of escape of bile into the peritoneal cavity with the development of a bile peritonitis. The second indication is in pancreatic damage where there is possibility of pancreatic juice escaping in the peritoneal cavity. In treating

bladder and rectal injuries drainage is imperative and it is important to be sure that the drainage is ample rather than insufficient. In the lower bowel, rectum, perineum, and posterior bladder injuries it is necessary to provide adequate drainage of the pre-sacral space. Thorough adequate drains in the retro-rectal and pre-sacral spaces cannot be too strongly stressed. If necessary remove a few segments of the coccyx. Stab type incisions for drainage in this region are not sufficient. Rectal wounds below the level of the peritoneum will heal without suture if given adequate drainage and diversion of the fecal stream by proximal colostomy.

Chemo-therapy

The treatment of wounds and the wounded with chemo-therapy underwent a remarkable change in the army between 1942 and the latter part of 1944. The routine instructions in 1942-43 followed the accepted principles in vogue at that time, dust every wound with sulfanilimide powder or crystals, no tissue being exempt from this dusting process. The general trend was to pour rather than dust, or sprinkle. Later there came about the various combinations of the sulfonimides and eventually penicillin added. The use of these drugs locally gradually ceased until early fall of 1945, when in my hospital the local application of sulfonimides and various combinations ceased entirely. The only local application of any drug, consisted of the injection of penicillin in solution into closed joint spaces and the pleural spaces after a repairative process with closure. However, chemo-therapy was industriously carried out by intravenous, parental and oral administration in all cases. The usual routine in all cases consisted of the following: 30,000 units of penicillin given intra-muscularly every three hours from time of admission and continued as long as needed; sodium sulfadiazine administered intravenously in six gm. daily doses immediately post-operatively and continuing until blood level reached 8 to 10 mg. per cent and patient able to tolerate the drug orally.

Post-Operative Care

Following operation these cases were placed in semi-Fowler position, oxygen given by nasal catheter and decompression accomplished by means of Levine tube and Wagensteen Apparatus. The Wagensteen suction apparatus functioned satisfactorily for suction. Ample morphine given for control of pain and discomfort. Delayed morphine poisoning is a real danger in the shocked cases and requires very careful observation and judgment. Chemotherapy has already been described in this paper. The fluid needs of the patient are determined by the intake and output chart, hematocrit, plasma determinations and other laboratory procedures. It is very important to meet the fluid requirements but just as important not to exceed the requirement. Many over-enthusiastic individuals tend to overdo the administration of fluids and literally drown the patient. In other words intelligent aftercare is vitally important to the patient and is another necessary link in the chain of recovery.

Post-Operative Complications

The most common complications in these cases are those usually associated with abdominal operations, thrombo-phlebitis, atelectasis, pneumonia, subdiaphragmatic abscesses, peritonitis, and wound infections. The incidence of these infections remained low in the cases properly treated, however, they should be looked for and when occur be treated in the accepted surgical manner.

Conclusion

An attempt has been made to briefly cover the salient points in the treatment of perineal and abdominal wounds as carried out under battle conditions in an advanced hospital, with stress being placed on the following:

Institution of immediate and vigorous treatment in all cases of shock and consider all cases of wounds of abdomen as potential shock cases.

Wounds of the perineum involving the abdomen are always serious and continue to carry a high mortality.

Outcome of the operation may depend on the time of operation in relation to the stage of shock and response of the patient.

Drain the peritoneal cavity only in cases of

Continued on page 48

*Treatment of Thermal Burns**

By Eugene P. McManamy, M. D., F. A. C. S., Portland, Maine

The recent disasters in civilian life coupled with World War II have brought an unprecedented concentration of burned victims under medical care in the past five years and consequently there has been a new impetus to the experimental study of the pathology as well as the therapy of burns and at present great strides are being made in the clinical approach to this problem.

This discussion will include some of the experiences encountered and impressions derived from the care of burned casualties in an Army General Hospital in the European Theater of Operations and also a survey of the recent literature on the problem of thermal burns.

It is important to establish a method of classification when dealing with burn cases. The classification used in this present discussion will be the customary one which has been in use in this country for several years and which divides the burns according to their depth, into three categories as follows: first degree, simple erythema of the skin; second degree, injury of the epithelium to include blistering and any further injury short of complete destruction of all of the epithelial elements; third degree, complete destruction of the full thickness of the skin.

Since it is also valuable to keep in mind the extent of a burn, some standard of the percentage of the body surface area should be maintained. Berkow's[4] "table" which is commonly referred to in the United States and Great Britain may be reviewed as follows:

a. In adults:
 1. The trunk consists of 38% of the body surface area.
 2. The lower extremities 38% of the body surface area.
 3. The upper extremities 18% of the body surface area.
 4. The head consists of 6% of the body surface area.

b. In children:
 1. The trunk consists of 40% of the body surface area.
 2. The lower extremities 38% of the body surface area.
 3. The upper extremities 16% of the body surface area.
 4. The head consists of 6% of the body surface area.

Although a fairly accurate estimate of the percentage of body surface area may be made when a burn occurs it is frequently impossible to determine definitely and correctly the depth of the burn.

During a thirty-two month period in which burn patients were admitted to this General Hospital, 70% were late cases and 30% were emergencies. The greatest majority of these cases were the result of high octane gasoline flames, either incurred during combat or from accident. This group of patients included all degree of burns, mainly of the second and third degree; and the involvement of the body surface area varied from 5 to 50%.

All the cases which were admitted, including the late cases as well as the emergencies, received a fairly standardized type of early local and general care, consisting of prompt attention, primary compression type of dressings, plasma chemotherapy and sedatives. All first and second degree burn cases were returned either to combat or limited service duty; while most of these cases which had incurred third degree burns were eventually transferred to the United States for further definitive care.

Treatment

The therapy of burns should be governed by sound surgical principles and can be divided into:

a. First aid care.

b. Early and late treatment of a local and general nature.

The treatment should be aimed at the problems which present themselves as the illness progresses.

* Presented at the 92nd Annual Session of the Maine Medical Association at Poland Spring, June 24, 1946.

First Aid Treatment

The first aid treatment of a burn casualty should be prompt, consisting of the covering of the burned area with clean or sterile compression dressings as recommended by Allen and Koch[3] to combat sepsis and plasma loss, placing the patient at rest, the giving of morphine for pain, and protecting the patient from exposure to extremes of heat or cold. First aid care should be instituted as soon as the patient is seen, whether it be at the scene of the accident or in the office. This original dressing is not to be removed until the patient can be cared for by masked, gloved, and preferably, gowned personnel.

Early General Care

The early general care of a burned patient is of paramount importance. The treatment is aimed towards the prevention and combating of:

a. Shock
b. Toxemia
c. Dehydration
d. Salt depletion
e. Anuria
f. Anemia
g. Acidosis
h. Sepsis

Early care should cover the first two to three days and be one of vigorous fluid therapy. Valuable help in estimating the progress of the case and important guides to the indicated therapy are frequent determinations of the following:

a. Hematocrit
b. Hemoglobin
c. Plasma protein
d. Blood chlorides
e. Carbon dioxide content
f. Non-protein nitrogen
g. Total urinary out-put

To prevent and combat shock, plasma is specific therapy as it restores blood volume and plasma proteins and it should be given with rapidity and in amounts which correspond to the needs of the patient from the clinical response as well as the other well known criteria. If laboratory facilities are not available at the moment, and until they are, the initial dose of plasma should be about 50 to 75 cubic centimeters for every percent of body surface burned.

Frequent hematocrit readings should be done and following Harkins[9] formula; 100 cc. of plasma should be given to the patient for every point that the hematocrit is above the normal of 45.

The initial dose of plasma should roughly correspond to about one-half of the estimated amount and when necessary it can be given rapidly. The remainder of the plasma can be given a few hours later.

In order to maintain normal blood volume and normal plasma proteins, plasma can be continued as indicated for the first forty-eight hours.

An attempt should be made to restore the normal hemoglobin concentration as soon as possible by giving blood transfusions. Harkins[9] advocates the giving of 500 cubic centimeters of whole blood for every 1000 cubic centimeters of plasma administered in patients who have a hematocrit reading below 60.

Glucose and normal saline solutions are necessary in the early general care and may be used to restore glycogen and salt depletion and aid urinary out-put. Care should be taken not to administer too large a dose of normal saline for fear of increasing edema and depleting the plasma proteins and perhaps aiding and abetting shock and toxemia.

Fluids by mouth such as milk and water should be started as soon as possible and the patient should be encouraged to drink adequately.

If acidosis develops, the carbon dioxide content of the blood should be determined and a solution of sodium bicarbonate should be given in amounts such as recommended by Cope[6] namely, 40 cubic centimeters of a 4 percent solution of soda bicarbonate for every volume percent that the plasma CO_2 is below 55 volume percent.

The fluid therapy mentioned above must be modified to suit each case and caution is recommended in the use of fluid therapy in cases in which co-incidental pulmonary edema may exist.

Early Local Care

The early local care of all but the most minor of first degree burns should be carried out under the most sterile conditions that can be obtained, in order to prevent contamination and subsequent intercurrent sepsis.

It was our custom to use the operating room and operating room technique for the first and often subsequent dressings. After removal of the first aid covering only gross contamination was removed from the burned area, no attempt was made to scrub or wipe the wound; in many instances the burned area was washed with warm normal saline. No debridement such as the opening or removal of blisters was done, and when previously applied medication was found present it was allowed to remain. In the early cases both sulfathiazol and sulfadiazine ointment were used freely to dress burns, however, later their topical use was discontinued and dressings such as described by Allen and Koch[3] were used, with as good results.

A fine meshed vaseline gauze was placed directly over the injured surface, over which was laid several layers of dry sterile gauze, over this a mass of fluffed sterile gauze which in turn was covered by sheet wadding smoothly and evenly applied and the whole was incorporated in a compression type of covering of either stockinet, for the face, head, and neck or ace bandages for the trunk and extremities. Not only do these compression dressings help to prevent fluid loss and edema but also act to cause immobilization of the part.

The successful use of close fitting plaster casts covering the whole of an extremity has been reported by Glenn,[8] Lund and Levenson.[13]

Tannic acid and triple dyes have been discarded for the most part as they delay epithelialization and tannic acid has been proven to cause liver necrosis.[7] Boric acid ointment is also falling into disrepute as it is apparently a central nervous system poison.[16]

Infection

To prevent the possibility of intercurrent sepsis developing in our cases definite procedures were carried out:

a. The use of chemotherapy, either topically or orally.

b. Later, the use of penicillin parentally.

c. Dressings were changed no oftener than absolutely necessary and were done in the operating theater or on the ward using the same careful technique as with the first dressings.

d. During warm weather the patient was protected against flies by the use of mosquito netting over the bed.

e. Maintaining normal blood volume and hemoglobin concentration.

In spite of these measures, intercurrent infections did develop; in some cases of the third degree type. Of the cases under our care which did develop intercurrent sepsis; the infection seemed to be well localized to the burn injury itself, showing purulent drainage and positive wound cultures, rarely was there evidence of the infection having spread into the surrounding tissue. We believe that chemotherapy may have played a part in this although we had no controls by which we could compare our results.

At the present time there is considerable doubt as to the value of the sulfonamides whether they be used locally or systemically, as a prevention against intercurrent sepsis in burn injuries. Meleney,[14] Levenson, Lund, Green and Taylor[12] among others are of the opinion that the efficacy of sulfonamides in the control of local infections has not been clearly demonstrated.

Late General Care

The late general care of burn cases should be concerned with maintaining normal amounts of blood volume, plasma protein, hemoglobin, electrolytes and an adequate urinary out-put.

Late Local Care

The late local care of a burn wound should consist in maintaining a clean wound, combating intercurrent sepsis, and achieving early coverage of third degree burns with skin grafts.

The organisms commonly cultured from our infected cases included: streptococcus hemolyticus, staphylococcus hemolyticus, coagulase positive, and in many cases there was a mixture of organisms which in addition to the above included many gram-negative bacteria, such as bacillus pyocyaneous, bacillus proteus, bacillus coli, diphtheroids and a host of other micrococci.

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The wounds which demonstrated mixed infections were the most difficult to handle, showed the least response to therapy and gave the poorest results in attempted skin grafts.

Attempts were made to combat infections by the use of the sulfonamides topically and systemically and by the use of penicillin parenterally and continuous saline packs locally. It was our impression that the use of penicillin and the saline soaks gave better results and it was often possible to achieve good results with skin grafts even in cases which persisted to show a mild exudate and positive wound cultures.

Levenson[10] and Meleney[14] found that hemolytic staphylococcus was present in almost every culture at any stage of the many burns that they studied and that this organism proved resistant to sulfonamide and penicillin but that its presence did not prevent successful grafting. Levenson[12] observed that when hemolytic streptococcus was predominant it did interfere with successful grafting in many cases but that it could be eliminated by the use of large doses of penicillin.

Since penicillin cream was not available we had no experience with it. It is reported to be of value in superficial burns.

Ackman and Smith[2] report disappointing results from the topical use of penicillin in wounds with preexisting infections. They attribute the failure of penicillin cream to check or destroy organisms in a wound to the fact that the penicillin is either rapidly destroyed or too rapidly eliminated from the wound to be of value even when large amounts are used.

Meleney and his co-workers[15] have recently demonstrated that the local use of penicillin is of questionable benefit or of no benefit at all in the treatment of many infected wounds in which there is a mixture of organisms. They believe that certain bacteria can produce metabolic products which are capable of destroying the growth inhibitory action of penicillin. Abraham and Chain[1] refer to this destructive agent as an enzyme and call it penicillinase. Amongst the different bacteria which can produce penicillinase is the group of areobic, non-spore forming, gram-negative rods, particularly the coliform, proteus, pyocyaneus, bacilli. This enzyme can destroy large amounts of penicillin so rapidly that it is impossible to keep a level of penicillin sufficiently high enough to destroy the susceptible species, such as staphylococcus aureus and hemolytic streptococcus. Also a consistent reduction of the level of penicillin below that required for bacteriostasis of the susceptible strains may cause these strains to become penicillin fast.

Meleney and his co-workers[15] recommend the use of some antiseptic to eliminate these organisms which form penicillinase. Of the antiseptics tested by them they found that parachlorophenal was the most effective and since it is compatible with penicillin suggest that the two agents be incorporated in a carbowax-proplyene glycol base for local use.

Tetanus bacillus was not cultured from any of our burn cases and we attributed this to the fact that all soldiers received frequent tetanus toxoid shots. All burn cases in which epidermis has been broken should receive tetanus antitoxin or a booster dose of tetanus toxoid if the patient has been previously immunized.

The necrotic slough should be removed from third degree burns at the earliest possible moment as it increases the incidence of infection and also delays skin grafting. Various procedures are advocated for the removal of this slough from a wound, such as the use of pyruvic acid, recommended by Connor.[5] In clean wounds we frequently removed the slough by excision, applied pressure dressings and in a few days were able to graft the area. In a very few cases that were free of infection the slough was excised and the graft was immediately applied with gratifying results.

Skin Grafting

Skin grafting which once belonged solely to the field of plastic surgery is now recognized as an important technique to be added to the practice of general surgery.

Every effort should be made to graft third degree burns as quickly as possible, so as to prevent the complications so common to open wounds; to protect the underlying structures, to restore the normal function to the part involved and shorten the illness.

The split skin graft is the easiest to handle and gives the best results in taking. The more exacting plastic procedures and full thickness grafts can be left for a much later date and to

Continued on page 46

Partial Intestinal Obstruction Due to Persistent Omphalomesenteric Duct

Richard T. Munce, M. D., Bangor, Maine

Congenital anomalies as causative factors in intestinal obstruction should be considered more frequently in the preoperative differential diagnosis. One of these, the persistence of the omphalomesenteric duct, first described in 1815 by Meckel, is subject to many pathological changes. It is generally not appreciated how often remnants of this duct may cause intestinal obstruction. In a series of 335 cases of obstruction reported by McIver from the Massachusetts General Hospital, 2.6% were due to Meckel's diverticulum. Sometimes associated with the vitelline duct will be found the omphalomesenteric vessels. These in themselves have been the cause of obstruction.

A brief review of the embryology will help to clarify the position and usual developmental course of these structures. The digestive tract of the fetus is joined to the yolk sac by an elongated tubular structure known as the omphalomesenteric or vitelline duct. As the amniotic sac grows, the duct with its accompanying vessels which enter the ventral surface of the embryo are pressed together and elongated. The amnion becomes applied to these structures to form the umbilical cord which suspends the embryo. In the 7 mm embryo the yolk sac loses its connection with the intestine and the duct becomes a solid cord which normally disappears. The vessels persist for a short time after the duct.

The two omphalomesenteric arteries pass through the mesentery of the intestine to the yolk sac. The left artery which encircles the bowel disappears. The right artery accompanies the duct through the course of the umbilical cord. This disappears before birth except for the portion which becomes the superior mesenteric artery. During the process of development, occasionally these changes do not occur as they should and the structures that should disappear sometimes remain. The following case represents one of partial intestinal obstruction resulting from the persistence of an omphalomesenteric duct.

MM was a 25-year-old single female who was sent to our hospital in November, 1945, with the complaint of pain in her lumbar region and left leg. Her family history and past history were non-contributory.

In April, 1945, while lifting a patient who was in a double hip spica, she experienced severe pain in her left lower back region. The pain persisted over the next week and began to radiate down her left leg along the sciatic distribution. She was seen at another hospital where a diagnosis of herniated disc was made. Because she failed to respond to bed rest and conservative measures she was sent to our hospital for surgery.

After the routine workup including careful neurological examination, she was taken to the operating room and a hemilaminectomy performed but no herniation of a disc was noted. Convalescense from this procedure was uneventful until 2 January, 1946, when she was allowed out of bed for the first time. She complained of moderate generalized abdominal pain, nausea, and mild dyspnea. The pain came on about one hour after she had eaten her usual evening meal. The pain was not localized but was generalized throughout the abdomen and was moderate in character, being slightly more severe in the epigastrium. With onset of pain she noted slight dyspnea and a feeling of pressure in her abdomen. There was no diarrhea or bloody stool.

She was seen in consultation by the general surgeons. Her temperature was 97.2; pulse, 90; blood pressure, 110/70. She remained quiet in bed but complained of some pain. Chest examination was negative. The abdomen revealed generalized tenderness, slightly more marked in the right lower quadrant. There was slight abdominal distension. There was mild increased peristalsis in both lower quadrants. No masses or spasm were noted. Rebound tenderness was present in the right lower quadrant. Laboratory data showed a white blood count of 8,800 with 56% segs. Urine was negative. Sedimentation rate was normal. The pain was relieved by codeine and

in about three hours the patient felt better and had a comfortable night.

The following morning she awoke feeling quite well. She was allowed out of bed and after being up for a very short time she again developed very severe pain in her lower abdomen, accompanied by nausea and vomiting. She was returned to bed and the pain disappeared without medication in about one hour. Examination at this time showed normal temperature. There was generalized abdominal tenderness with no definite spasm. Laboratory work was about the same as stated above. That afternoon she was again permitted to get out of bed to see whether the pain would recur. Again after being up only a short time, the pain became very severe and was followed by vomiting. This time there was mild lower abdominal spasm. It was felt that she had a surgical condition and accordingly on the following morning a laparotomy was performed.

Under general anesthesia, the peritoneal cavity was opened through a right rectus incision. Some clear fluid was encountered. The pelvic organs were normal to palpation. The cecum was delivered and the appendix was noted to be mildly inflamed. It was removed and the stump was inverted with a purse string silk suture. It was questionable that the pathology in the appendix could account for the degree of pain that the patient experienced, and accordingly further exploration was carried out. The incision was enlarged and several loops of ileum were found distended. A firm cord-like structure was found originating about fourteen inches proximal to the ileo-cecal valve. This passed along the course of the ileum on the anti-mesenteric side for about two inches, closely attached to the ileum by firm adhesions. It then made a sharp turn, crossing the bowel at a thirty degree angle, proceeding up through a hole in the omentum and then posteriorly and downward to attach itself to the terminal ileum. It appeared as though the omentum had wrapped itself around this cord. In this angular course it crossed the bowel in three places and caused obstruction to about ten inches of ileum. It was apparent that in a standing position greater pressure was placed on the bowel by the cord, accounting for the recurrent onset of pain when the patient stood up. The cord-like structure was severed at the terminal ileum and then traced back to its origin. Both the proximal and distal ends were cut and tied with fine silk. There was no direct opening of this structure into the bowel. The structure itself contained a blood vessel near its central portion. The wound was closed in layers with fine silk. The patient made an uneventful recovery. She was allowed out of bed on her second postoperative day and there was no recurrence of abdominal pain. A follow-up report four months later stated that the patient had returned to nursing duties and was asymptomatic.

On pathological examination the appendix showed dilated tortuous subserosal vessels. Section showed obliteration of the lumen and infiltration of the wall with mononuclear cells, plasma cells, and eosinophilic leucocytes. There was an exudate present on the serosal surface. A diagnosis of chronic obliterative appendicitis was made. The cord-like structure measured twelve centimeters in length. The surface was covered with a smooth layer of serosa and the diameter varied from three to one millimeter. On cut section there was a small opening, the wall of which was composed of dense greyish white tissue. The lumen of the vessel contained red blood cells. There were sclerotic changes in the wall consisting of hypertrophy of the media. The surrounding muscular layers simulated those of the small intestine. It was felt that all remnants of the mucosal elements had been destroyed. The cord-like structure represented incomplete obliteration of the omphalomesenteric duct. It is probable that the sclerotic vessel represented a vestigal of the omphalomesenteric vessel.

This case is interesting when you consider the influence of change of position on the symptoms. It emphasizes the role of the omphalomesenteric duct as a factor in intestinal obstruction. It reemphasizes the importance of further and careful exploration when it is felt that the pathology as represented in the appendix is insufficient to explain the patient's symptoms.

References

Arey, L. B.: Developmental Anatomy.
McIver: *Arch. Surg.*, 25:1101, 1932.
Fitz, R. H.: Persistent Omphalomesenteric Remains. *American Journal of Medical Science*, 88:30, 1884.
Postloff, A. V.: Obstruction Due to Persistence of Omphalomesenteric Artery. *Ann. Surg.*, Feb., 1946.

Editorials

80 Voluntary Health Plans in 33 States Cover Four Million

"Driving to complete the voluntary health insurance program for the care of the American people is the big job facing local, state and national medical organizations today," according to Thomas A. Hendricks, secretary of the Council on Medical Service of the American Medical Association. "More than 80 plans sponsored by medical societies in 33 states covering 4,000,000 persons are now in operation and the task has just begun.

"The pioneering state of voluntary health insurance is nearing completion and nationally, we are rapidly entering the development stage. Only two states do not have a plan operating or in the process of formation. Plans for a prepayment program are now being made in 13 states and the District of Columbia. Growth of the plans now in operation has been rapid, the over-all expansion within the last six months being as phenomenal a production figure as has appeared in modern insurance records.

"The enrollment in prepayment plans has accelerated slowly. This was partly due to the difficulties developed in the early experimentation stages through which such plans had to pass, and partly to hesitancy on the part of doctors to plunge into an untested field of endeavor. As the number of plans has increased, so too has the acceleration in enrollment. During 1945, the over-all increase was 114 per cent. For the first six months of 1946, the enrollment increase was approximately 40 per cent, bringing the total to nearly the 4,000,000 mark. Indications are that enrollment will reach 5,000,000 by early 1947.

"One of the objectives of the Council on Medical Service is to present the facts in regard to advantages and disadvantages of the various plans, keep records up to date on all new developments in the medical care field, conciliate differences of opinion as to the various forms of insurance—in short, view the entire question impartially and objectively in order to do everything possible to encourage the wholehearted acceptance by every state society of a practical, workable plan.

"The whole insurance program is still experimental. No one knows the complete answer. Hence, the council hopes to encourage all types of plans that meet the minimum requirements set by the council to maintain the standard of medical service for the protection of the public.

"The council is now set up to do the job of (1) encouraging development of new plans; (2) keeping the profession informed as to developments, and (3) helping to increase the enrollment of plans already established."

Clinical Pathological Exercise

A new feature of the JOURNAL will be a series of Clinical Pathological Exercises, sponsored by the Committee on Graduate Education. These Case Reports will come from the Maine General Hospital, Eastern Maine General Hospital, and Central Maine General Hospital, and will be edited by Dr. Joseph E. Porter, of Portland, a committee member. The first of the series will be found on page 38 of this issue.

Clinical Pathological Exercise

Edited by Joseph E. Porter, M. D.

MEDICAL CASE # 56904 HELD AT MAINE GENERAL HOSPITAL

This is the case of a 55-year-old white married contractor and shipyard worker, whose chief complaint was fatigue and weakness of about three years' duration. He noted that he tired easily, and as time went on his lassitude increased and weakness became a prominent symptom. Two years before admission patient stated that he had a "nervous breakdown." He was not hospitalized, but had to stop working; he was agitated, shook a good deal, and felt compelled to walk for long distances; he felt that if he stopped walking he would never be able to walk again. About four months before admission he started working again, but weakness and fatigue again troubled him, to the extent that he sought the advice of his family physician. He never experienced any pain, nausea, or vomiting. He lost 15 pounds in weight during the past few months before admission. His appetite had been fair. Past History: He stated that he had the usual childhood diseases, but denied any serious illnesses or operations. About 12 to 13 years before admission, while returning home from a fishing trip, he experienced a sensation of pins and needles in both feet. He went to work the following day, but had to return home because of pain. The next day he noticed that the skin began to peel from his hands and the soles of his feet. Shortly after that, his toenails and fingernails began to loosen, and by the end of 3 weeks he had lost all of his nails. There were no changes in the hair, and he did not have a rash. He felt well, other than for the first two days of this episode. His nails grew back over a period of months. He stated that he used "Renuzit" on numerous occasions to clean clothes during the past few years before admission. He used a paint remover from time to time in his business. While in the shipyard, he used a fluid to clean his hands of paint and grease; this fluid was for the general use of all the shipyard employees. The patient smoked a pack of cigarettes daily. He had been married for 33 years; his wife was 67 years of age, and in good health. There was one daughter 24 years of age, in good health. Family History: Father age 79, mother age 73, living and well. One brother, age 51, and one sister, age 42, both living and well.

Physical Examination: Temperature 98.6°, pulse 90, respirations 22, B. P. 140/70. Head was symmetrical. Eyes clear; pupils reacted to light and accommodation. The external ear canals were not remarkable. The mouth was in fair condition. The tongue protruded in midline. The mucous membranes were pale. Neck: Thyroid not palpable; no glands were felt. Lungs were clear to percussion and auscultation; no rales were heard. The heart was not enlarged; rhythm was regular; no murmurs were heard; the sounds were of good quality. The abdomen was flat; no tenderness or spasm. There was a large mass on the left side, extending down to the crest of the ilium. The liver was not palpated. There were small direct bilateral herniae. Genitalia were normal adult male. Extremities: No pitting edema; pulsations present in the peripheral vessels. Rectal examination was not remarkable.

Laboratory work: On admission, RBC. 2,620,000; Hb. 42%, or 6 gm.; WBC. 15,700; differential: Myelocytes 10%, metamyelocytes 9%, band forms 33%, mature forms 13%, lymphocytes 18%, monocytes 3%, nucleated RBC. 14%. There was marked variation in size of the RBC.; there were a few microcytes and occasional polychromatophilic cell, with some tailed forms. The corrected sedimentation rate was 16 mm./hr. (Wintrobe). The hematocrit was 20. Platelets appeared to be diminished in the smear. RBC. fragility 0.45-0.33 (control 0.45-0.27). Blood Kahn and Hinton were negative. Prothrombin time 20 sec., normal control 20 sec. Urine: Clear; acid; S. G. 1.022; no albumin, sugar, acetone, diacetic, or bile. Sediment contained a rare WBC., no RBC., no casts; occasional epithelial cell. On the 4th hospital day a sternal marrow biopsy revealed no myeloblasts; myelocytes 8%; juveniles 10%; polys 8%; megaloblasts 2%;

nucleated RBC. and normoblasts 68% ; lymphocytes 4%.

On the 4th hospital day a K. U. B. X-ray revealed a soft tissue shadow involving the whole left side of the abdomen, from the diaphragm down to the iliac crest. Kidney outline could not be made out. An intravenous pyelogram showed prompt excretion on the right, but no excretion on the left after 40 minutes. On the 6th hospital day a cystoscopy and retrograde pyelogrom was done. The bladder was normal; the prostate was enlarged, Grade II. The ureters were easily catheterized, but on the left the catheter could only be passed for a distance of 20 cm. X-ray showed the right catheter in the region of the renal pelvis; the left catheter was in the middle third of the left ureter.

On the 10th hospital day the Hb. was 36%, 5.2 gms.; RBC. 2,230,000; WBC. 27,000; differential: Meamyelocytes 6%, bands 24%, mature forms 10%, eosinophils 2%, lymphocytes 2%, nucleated RBC. 56% ; a rare platelet was seen.

On the 19th hospital day a splenectomy was performed. On the 23rd hospital day X-rays of both femora, humeri, pelvis, lumbar spine, and lateral view of the skull revealed no changes in bone density. Pre-operatively, the patient received one transfusion. During the operation two transfusions were given. During the period of convalescence 4 transfusions were given. The patient was discharged on the 31st hospital day, 21 days after operation, at which time the Hb. was 59%, 8.2 gms.; RBC. 2,730,000; platelets appeared normal in smears. There was moderate variation in size and shape of the RBC., with a rare nucleated RBC.

Three months after discharge the Hb. was 28%, 4 gms.; RBC. 1,032,000; WBC. 32,500; there was marked variation in size and shape of RBC., with macrocytes, microcytes, and considerable polychromatophilia. The differential showed: Myeloblasts 2%, myelocytes 11%, metamyelocytes 6%, bands 10%, polys 7%, lymphocytes 5%, monocytes 1%, nucleated RBC. 58%. The platelets were scanty in smears.

Discussion

Dr. Ralf Martin: The chief points in this case record might be summarized as follows: Symptom—weakness. Physical examination—an enlarged spleen. Laboratory—severe anemia, leukocytosis, with marked shift to the left, large number of nucleated red blood cells in the peripheral blood; a bone marrow showing hypoplasia in the granulocytic series, and hyperplasia in the red blood cell series. After splenectomy there was some change in the blood picture, but no improvement in the anemia. In any given case, it is difficult to say which are the most prominent symptoms and signs, but for the sake of differential diagnosis, let us take those of anemia and splenomegalia. There are many conditions or disease syndromes where these findings are present, but which will not be mentioned because of obvious reasons. There are others which will not be discussed, even though splenomegalia and anemia may be prominent, such as Von Jaksch's anemia or Niemann-Pick's disease, both of which occur only in infants and children. One might possibly entertain typhoid fever, but this man has no record of having had any fever, and as far as I know, the spleen never becomes this large. There is, however, no report on the Widal. Malaria might be considered, and oddly enough, I am not completely able to rule this out. However, no parasites were reported in the blood smear, and again, there is no evidence of chills and fever. Lymphosarcoma should be mentioned, but here again, fever is a rather constant finding, and the lymph glands are almost without exception a prominent feature. In Hodgkins' disease also enlarged glands are almost always present. The white blood count as a rule is normal, and here again, the patient as a rule has periodic fever. I have never known Hodgkins' disease to have such an abnormal white cell picture. Gaucher's disease, although it usually begins in childhood, may extend into adulthood, but in this condition a leukopenia is invariably present. The description of the red blood cells might lead one to think of pernicious anemia, but the white blood count is quite atypical, and, I think, rules out pernicious anemia, which almost invariably has a normal or low white blood cell count. Also, I have never known an individual with pernicious anemia to have such a large spleen. In Kala-Azar, leukopenia again is always present, and these patients have tremendous livers, along with the enlarged spleen. We have no evidence here that this patient has an enlarged liver. Banti's disease must also be

considered, but here again, leukopenia is almost always the rule. This brings me down to two conditions which pathologically may seem to be quite far apart, and with this I agree.

(Question): What was the appearance of the stools?

Dr. Porter: His stool was not examined. From conversation with this man, however, we gathered that he never showed any changes in the stools as to color.

(Question): What was the urobilinogen content of the urine?

Dr. Porter: That was not done.

(Question): What was the Icterus Index?

Dr. Porter: Neither of those tests were done.

(Question): Was a Van den Bergh reaction performed?

Dr. Porter: I don't believe so. He was never jaundiced.

(Question): Were there any parasites in his smears?

Dr. Porter: No, there were none.

Dr. Martin: The answers to my questions confuse me considerably, as I felt I had built up a certain amount of evidence that this man probably had acquired hemolytic anemia. Here is an individual who has rather marked evidence of increased red blood cell production, and if there is no hemorrhage, and we have no evidence of hemorrhage, then increased red blood cell production in the face of anemia is certainly excellent evidence of red blood cell destruction. The condition which would best fit this picture is acquired hemolytic anemia. However, since Dr. Porter has the definite conviction that there was no increased bilirubin in the blood, and no increased urobilinogen in the urine, I must be wrong in this diagnosis. My second diagnosis was leukemia. There are several things for and several against this diagnosis. Certainly, the symptoms would fit in well. Also the fact that he had a very large spleen and a marked anemia, with a decided shift to the left, as well as a decrease in platelets, might argue in favor of leukemia. Against it is the fact that no glands were present, and there were large numbers of circulating red blood cells. The bone marrow is also not characteristic, in that the white blood cell series showed actual depression, while the red blood cell series showed hyperplasia. As is obvious from what I have learned since I started discussing this case, there are numerous loopholes in both of my favorite diagnoses. Nevertheless, since I haven't a better one, I'll go on record with Number 1 being acquired hemolytic anemia, and Number 2 leukemia. Now we come to this peculiar affair that he had 10 or 12 years ago, when he became ill and lost his fingernails and toenails. I am sure I have no idea what caused this peculiar affair. I even went so far as to call Dr. Babalian, and although he could find no definite reference in the literature available to him, he felt that it had been described in certain blood dyscrasias where there was marked blood destruction with hemoglobinuria and an associated Raynaud's type of thing which caused loosening of the nails. Now I have assumed throughout this discussion that the mass in the left upper quadrant was the spleen. Dr. Porter, would you like to see his X-ray?

Dr. Thaxter: In the first place, from the record it says there was no function on the left side. I do not remember saying anything about function on the left side. It is apparently not the kidney, because the kidney is pushed down by the mass.

Dr. Ives: Was a gastric analysis ever done?

Dr. Porter: No, never done.

Dr. Martin's Diagnosis

1. Acquired hemolytic anemia.
2. Leukemia.

Anatomical Diagnosis

Agnogenic myeloid metaplasia.

Dr. Porter: The operative specimen consists of a spleen which is greatly enlarged, weighing 1500 gms. The striking feature of this specimen was its microscopic appearance, which characterizes this condition. The major portion of the tissue consisted of myelopoietic tissue, in which both members of the red cell series and the white cell series were growing and

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President, Richard P. Laney, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Carl H. Stevens, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

100% Paid Membership for 1947

Piscataquis County Medical Society

Cumberland

A regular meeting of the Cumberland County Medical Society was held at the Mercy Hospital, Portland, Maine, on January 30, 1947, Dr. Edward A. Greco presiding. At 5.00 p. m., an interesting group of gastric lesions was presented at a clinic and discussed by the speaker of the evening. An excellent dinner was served at 6.30 p. m., and the meeting was called to order at 8.00 p. m.

Dr. Thomas A. Foster urged the members to return their uncompleted surveys on Child Health to him at their earliest convenience.

Dr. Frank Broggi, who has been a member of the Massachusetts Medical Society, was unanimously elected to membership in the Cumberland County Medical Society.

The principal speaker of the evening was Dr. Francis D. Moore, Associate in Surgery at the Harvard Medical School, and Assistant Surgeon at the Massachusetts General Hospital. His paper was entitled "Recent Changes in Treatment of Duodenal Ulcer." He presented in a most enthusiastic and energetic manner the newer approaches to the surgical treatment of duodenal ulcer, consisting essentially in resection of the vagus nerve. He briefly outlined in chronological order the various previous works which have been done in demonstrating the neurogenic causes of ulcer, and the alterations in gastric physiology resulting from denervation of the stomach. In certain cases vagotomy is a very effective method of treating duodenal ulcers, resulting in relief of pain, healing by X-ray, decrease in acidity and motility of the stomach. Untoward effects, consisting of diarrhea in about 25% of the cases, constitute the most pronounced deterrents from this operation. Patients show a weight gain, and their appetite is usually normal. The paper was discussed by Drs. Webber, O'Donnell, and Parker.

Joseph E. Porter, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Thursday evening, January 9, 1947, at 6.30 p. m.

It was moved and seconded that the Officers of the Society draw up a set of resolutions on the death of Arthur H. Parcher, M. D. This motion was carried.

Joseph Ross, M. D., of the Massachusetts Memorial Hospital, Boston, spoke to the society on "The Use of Radioactive Isotopes in Medicine," which was followed by a general discussion.

J. H. Crowe, M. D.,
Secretary.

Kennebec

The annual meeting of the Kennebec County Medical Association was held at the Augusta State Hospital, Augusta, Maine, December 19, 1946.

Dinner at 6.30 p. m. was followed by the business meeting. Minutes of the October and November meetings were read and approved. The reports of the Secretary-Treasurer were read and approved.

The following Officers were elected for the ensuing year:

President, Frank B. Bull, M. D., Gardiner.

Vice President, William L. Gousse, M. D., Fairfield.

Secretary-Treasurer, Arch H. Morrell, M. D., Augusta.

Councilors: Harold E. Small, M. D. (1947); Charles E. Towne, M. D. (1948); Allan C. Hurd, M. D. (1949).

Delegates to the Maine Medical Association: Clarence R. McLaughlin, M. D., Gardiner (one year); Thomas C. McCoy, M. D., Waterville (two years); and Theodore E. Hardy, M. D., Waterville (three years). Alternate, Wilson H. McWethy, M. D., Augusta.

Dr. Frank S. Broggi, of Portland, presented a paper on "Shock Therapy and Newer Concepts in Psychiatric Treatment," which was followed by Dr. Francis H. Sleeper's paper on "Some Psychiatric Problems Confronting the General Practitioner." Both papers were very well presented and were followed by an unusual amount of interesting discussion.

A clinical session at 5.00 p. m., with presentation of cases by the hospital staff, preceded the evening meeting.

There were 39 members and guests present.

A. H. Morrell, M. D.,
Secretary.

A regular meeting of the Kennebec County Medical Association was held at the Elmwood Hotel, Waterville, Maine, January 15, 1947.

Supper at 6.30 p. m., was followed by the business meeting which was called to order by President Frank B. Bull.

The minutes of the preceding meeting were read and approved.

Dr. George L. Wadsworth, of the U. S. Veterans' Hospital, Togus, Maine, was admitted to membership by transfer from the Rhode Island Medical Society.

Dr. Walter W. Jetter, of the Medico-Legal Department, Harvard Medical School, gave a talk entitled "Medical Examiner's Cases." He indicated that a certain proportion of the deaths in a community need investigation, being violent deaths, and that a post-mortem is an essential part of some of the cases, otherwise the guilty may escape, while frequently suspected persons will be cleared.

A brief discussion period followed.

The 25 members and guests present are to be commended for being there in spite of very bad traveling.

A. H. Morrell, M. D.,
Secretary.

Penobscot

A regular meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, January 21, 1947, at 6.30 p. m.

Dr. Lewis M. Hurxthal, Chief of Medicine at the Lahey Clinic, Boston, spoke on "Thyroid Disease." This paper was exceptionally well presented and an open discussion followed.

Three new members were elected to the Society: Arthur N. Lieberman, M. D., Bangor; Francis W. Bradbury, M. D., Brewer; and Robert J. Barrett, Jr., M. D., Bangor.

There were 55 members and nine guests present.

J. E. Smith, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at The Greenville Hotel, Greenville, Maine, Sunday, January 19, 1947. A very nice dinner was served to 23 members and guests at 2.30 p. m.

Dr. Richard P. Jones, of the State Department of Health and Welfare, conducted a round table discussion on "Syphilis." It was an instructive and agreeable meeting.

N. H. Nickerson, M. D.,
Secretary.

Somerset

A meeting of the Somerset County Medical Society was held December 10, 1946.

Two new members were voted into the Society: H. Carl Amrein, M. D., Madison; and Donald F. Larkin, M. D.. Bingham.

Dr. Milan Chapin, Assistant Medical Director of the Central Maine General Hospital, Lewiston, gave a very interesting and instructive talk on "Antibiotics in Medicine."

Maurice E. Lord, M. D.,
Secretary.

York

The annual meeting of the York County Medical Society was held at the Kennebunk Inn, Kennebunk, Maine, January 8, 1947.

The following Officers were elected for the ensuing year:

President, Oscar W. Perrault, M. D., Biddeford.

Vice President, Paul S. Hill, Jr., M. D., Saco.

Secretary-Treasurer, Charles W. Kinghorn, M. D., Kittery.

Board of Censors: J. R. LaRochelle, M. D. (1947); G. R. Smith, M. D. (1948); and H. D. Ross, M. D. (1949).

Delegates to the Maine Medical Association: J. H. Macdonald, M. D., Kennebunk; Dr. Kinghorn, and David E. Dolloff, M. D., Biddeford. Alternates: Paul S. Hill, Jr., M. D., Saco; Dr. Perrault, and Alexander W. Magocsi, M. D., York Village.

The annual report of the Secretary-Treasurer was read and accepted.

Dr. Stephen A. Cobb, President-elect of the Maine Medical Association, gave a talk on the organization of a Medical School at the University of Maine. It was voted that the Society go on record in favor of a Medical School.

Anthony Bananno, M. D., of Berwick, was admitted to membership in the Society.

Dr. Albert C. Johnson, of Portland, spoke on "Otitis Media."

There were 20 members and one guest present.

C. W. Kinghorn, M. D.,
Secretary.

New Members

Cumberland

Frank S. Broggi, M. D., Portland, Maine.

Kennebec

George L. Wadsworth, M. D., Togus, Maine. (By transfer from the Rhode Island Medical Society.)

Penobscot

Robert J. Barrett, Jr., M. D., Bangor, Maine.
Francis W. Bradbury, M. D., Brewer, Maine.
Arthur N. Lieberman, M. D., Bangor, Maine.

Somerset

H. Carl Amrein, M. D., Madison, Maine.
Donald F. Larkin, M. D., Bingham, Maine.

York

Anthony Bananno, M. D., Berwick, Maine.

News and Notices

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., 192 State Street, Portland, Secretary.

List of Physicians Licensed in the State of Maine, November 13, 1946.

Through Examination

Dr. John F. Appel, Holyoke, Mass.
Dr. Raleigh W. Baird, Jr., Boston, Mass.
Dr. Robert A. Beaudoin, Berlin, N. H.
Dr. Ronald A. Bettle, Cape Elizabeth, Maine.
Dr. Frank Scannell Broggi, Portland, Maine.
Dr. Irving E. Brown, Jr., South Portland, Maine.
Dr. Lyman C. Burgess, Tilton, N. H.
Dr. Norman K. Chesley, Portsmouth, N. H.
Dr. Robert Cole Cornell, Orono, Maine.
Dr. John J. Doyle, West Medford, Mass.
Dr. Ernst Eppinger, Rockville, Conn.
Dr. Rino Fournier, Edmundston, N. B.
Dr. J. Armand Gelinas, Fitchburg, Mass.
Dr. Daniel Francis Hanley, Brunswick, Maine.
Dr. Robert G. Livingstone, Boston, Mass.
Dr. Avard C. Long, Hampton, N. H.
Dr. Jay Beverly Moses, Bangor, Maine.
Dr. Elmer M. Sewall, Bangor, Maine.
Dr. Duncan C. Smyth, Portland, Maine.
Dr. Edward H. Soule, Portland, Maine.
Dr. John R. Sullivan, Brownville Junction, Maine.
Dr. Philip Haskell Sylvester, Damariscotta, Maine.
Dr. Robert Lee Taylor, Portland, Maine.
Dr. George L. Temple, Lewiston, Maine.
Dr. Frederick A. Waldron, Portsmouth, N. H.
Dr. John S. Walker, Kittery, Maine.

Through Reciprocity

Dr. David S. Ascher, Boston, Mass.
Dr. Robert J. Barrett, Jr., Bangor, Maine.
Dr. Mason D. Bryant, Jr., Lowell, Mass.
Dr. Philip B. Chase, Pittsburgh, Pa.
Dr. Edwin B. Davis, Jr., Boston, Mass.
Dr. Jesse McCanless Galt, Dover, N. H.
Dr. James P. Hepburn, Milton, Mass.
Dr. Christian K. C. Hoyle, Kittery, Maine.
Dr. Calvin F. Jackson, Charleston, West Virginia.
Dr. Robert S. LaFond, Westbrook, Maine.
Dr. George Loewenstein, Chicago, Ill.
Dr. Roy Ray, Daytona Beach, Fla.
Dr. Maurice Ross, Biddeford, Maine.
Dr. Herbert H. Schoenfeld, Washington, D. C.
Dr. Charles L. Tuttle, Brunswick, Maine.

Bureau of Health

State Services for Crippled Children Clinic Schedule, 1947

Portland—Children's Hospital, 9.00-11.00 a. m.: Jan. 13, Feb. 10, Mar. 10, Apr. 14, May 12, June 9, July 14, Aug. 11, Sept. 15, Oct. 13, Nov. 10, Dec. 8.

Lewiston—Central Maine General Hospital, 9.00-11.00 a. m.: Jan. 24, Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 29, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Rumford — Community Hospital, 1.30-3.00 p. m.: Apr. 16, June 18, Aug. 20, Oct. 15, Dec. 17.

Waterville—Thayer Hospital, 1.30-3.00 p. m.: Feb. 27, Apr. 24, June 26, Aug. 28, Oct. 23, Dec. 18.

Rockland—Knox County Hospital, 1.30-3.00 p. m.: May 15, Aug. 14, Nov. 13.

Machias—Normal School, 1.30-3.00 p. m.: Apr. 9, July 16, Oct. 22.

Presque Isle — Northern Maine Sanatorium, 9.00-11.00 a. m.: Jan. 7, Mar. 5, May 6, July 9, Sept. 9, Nov. 5.

Houlton — Aroostook General Hospital, 9.00-11.00 a. m.: Mar. 4, July 8, Nov. 4.

Fort Kent — Normal School, 9.00-11.00 a. m.: Jan. 8, May 7, Sept. 10.

Bangor—Eastern Maine General Hospital, 1.30-3.00 p. m.: Mar. 27, May 22, July 24, Sept. 25, Nov. 20.

Portland — Cardiac, Maine General Hospital, 10.00-12.00 a. m.: Will be held every Friday with the exception of holidays (May 30, July 4, and Dec. 26).

State Pediatric Clinic Schedule, 1947

Bangor — Eastern Maine General Hospital, 1.30 p. m.: Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 22, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Waterville — Thayer Hospital, 1.30 p. m.: Jan. 7, Mar. 4, Apr. 1, May 6, June 3, July 1, Aug. 5, Sept. 2, Oct. 7, Nov. 4, Dec. 2.

Presque Isle — Northern Maine Sanatorium, 1.30 p. m.: Mar. 26, May 21, July 23, Sept. 24, Nov. 19.

Clinic visits by appointment only. Referrals may be sent to: Division of Services for Crippled Children or Division of Maternal and Child Health, State Bureau of Health, Augusta, Maine.

Committee on Graduate Education

Panels Available for Programs of County Medical Associations

The Committee on Graduate Education has available for programs of County Medical Associations the following panels:—

"Diagnosis and Treatment of Accessible Cancer." Chairman—Dr. J. E. Porter, Maine General Hospital, Portland.

"Coronary Disease." Chairman—Dr. W. J. Comeau, Eastern Maine General Hospital, Bangor.

"Thoracic Injuries." Chairman—Dr. George E. Young, Redington Memorial Hospital, Skowhegan.

"The Acute Abdomen." Chairman—Dr. William V. Cox, Central Maine General Hospital, Lewiston.

"Renal Disease." Chairman—Dr. Eugene H. Drake, Maine General Hospital, Portland.

"Deafness." Chairman—Dr. Frederick T. Hill, Thayer Hospital, Waterville.

These panels will be available, not only for the formal evening program but for an afternoon clinic as well, if this is desired. County officers should contact the chairman of the desired panel direct and sufficiently in advance of the meeting to allow scheduling.

Frederick T. Hill, M. D., *Chairman, Committee on Graduate Education.*

The Ophthalmological Study Council

The Ophthalmological Study Council, which has already given two large graduate courses in the basic subjects of Opthalmology, is arranging to conduct a course in Portland, Maine, this summer.

The Westbrook Junior College has offered its facilities for housing and meals, as well as the use of its lecture rooms. The course will run from the middle of June to the middle of September. The same curriculum and teachers are expected as at the previous large courses at Boston, Massachusetts, and St. Petersburg, Florida. This will be the last course of the series given by the Council.

Those interested should get in touch with the Ophthalmological Study Council, 520 Commonwealth Avenue, Boston, Massachusetts.

State Medical Society Dues in U. S.

A study of dues paid to state medical societies has recently been completed by the Oklahoma State Medical Association. There is particular interest in that part of the tabulation which shows changes in assessment in 1945 and 1946 and increases proposed for 1947.

	DUES			ASSESSMENT		
State	1945	1946	1947	1945	1946	1947
Alabama	5.00	5.00	5.00			
Arizona	30.00	30.00	30.00			
Arkansas	5.00	5.00	5.00			
California	20.00	100.00	100.00			
Colorado	18.00	18.00	50.00			?
Connecticut	20.00	20.00	?			?
Georgia	7.00	7.00	7.00			
Idaho	12.00	12.00	12.00			10.00
Illinois	8.00	8.00	10.00			?
Indiana	15.00	15.00	10.00			
Iowa	10.00	10.00	15.00			
Kansas	15.00	15.00	15.00			
Kentucky	5.00	15.00	?			
Louisiana	25.00	25.00	25.00			
Maine	12.00	12.00	35.00			
Wash., D. C.	30.00	30.00	?			?
Michigan	12.00	12.00	?	10.00	25.00	?
Minnesota	20.00	20.00	20.00			
Mississippi	5.00	5.00	5.00			
Missouri	8.00	8.00	8.00	7.00	7.00	7.00
Nebraska	15.00	15.00	15.00			
New Hampshire	6.00	6.00	10.00			
New Jersey	22.00	20.00	25.00			
New Mexico	10.00	10.00	20.00			
New York	10.00	10.00	10.00			
North Dakota	35.00	35.00	35.00			
Ohio	7.00	7.00	15.00			
Oklahoma	12.00	12.00	22.00		25.00	
Oregon	20.00	20.00	?	10.00	10.00	10.00
Pennsylvania	20.00	20.00	?			
Rhode Island	25.00	25.00	?			?
South Dakota	15.00	15.00	50.00			
Tennessee	6.00	15.00	15.00			
Texas	20.00	20.00	20.00			
Utah	15.00	15.00	50.00			
Vermont	20.00	20.00	35.00			
Virginia	7.00	7.00	?	2.00	2.00	?
Washington	20.00	20.00	25.00			
West Virginia	10.00	15.00	15.00	5.00		
Wisconsin	33.00	33.00	?			?
Wyoming	7.50	7.50	25.00			

? Indicates figures not yet decided upon by meeting of House of Delegates.

Clinical Pathological Exercise—Continued from page 40

maturing, also numerous megakaryocytes. The condition is quite similar to leukemia, and has been previously described by Jackson, Parker, and Lemon.[1] While we considered this case one in which the etiology is unknown, it is possible that it may have been provoked by an exposure to benzol poisoning; however, we have not been able to obtain any history from the patient of any excessive exposure to benzol.

Dr. Lorimer: What is his ultimate prognosis?

Dr. Porter: The ultimate prognosis is poor; which brings up the reason for the presentation of this case, and that is, if the clinical diagnosis had been correctly made preoperatively, it would have been wiser not to have removed the spleen, inasmuch as a large source of blood formation has now been removed, with the result that this man has shown a more pronounced degree of anemia postoperatively than he did before the spleen was removed. It is now about 5 months since the operation, and he is still alive but weak, and his red count averages around 1.5 to 2 million.

BIBLIOGRAPHY

1. Jackson, Henry, Jr., Parker, Frederick, Jr., and Lemon, H. N.: *N. E. Journal of Medicine,* Vol. 222, p. 985, June 13, 1940.

Pay Your 1946 State and County Dues Promptly to Your County Secretary

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Treatment of Thermal Burns—Continued from page 32

the plastic surgeon when such definitive treatment is indicated. We found that the Padgetts dermatome proved to be the most satisfactory instrument in our hands, for cutting split skin grafts.

Exercise

Active and passive motion may be important in the treatment of burns and should be instituted early enough to prevent loss of function of the part. This is especially so where burns involve the skin about joints, hands and fingers.

We found it valuable to begin motion in burned hands as soon as the edema had subsided. Twice a day a patient's hand was submerged in a sterile saline bath for twenty minute periods and active motion encouraged under supervision with excellent results. This procedure was carried out until skin could be grafted to the hand which meant that by the time the graft had taken the patient not only had a healed wound with skin on it but also had motion.

Summary and Conclusion

(1) Compression type of dressing as described by Allen and Koch is of value to combat fluid loss and sepsis.

(2) The early general care of a burn victim consists in combating shock, toxemia, dehydration, anemia, and is one of vigorous fluid therapy.

(3) The late general care should be devoted to restoring to normal and maintaining a normal blood volume, hemo-concentration, electraly to balance and plasma proteins.

(4) The local care of a burn wound should consist in preventing and combating sepsis by using sterile precautions at all times, by frequent dressings and by early coverage of third degree burns with split skin graft.

References

1. Abraham, E. P., and Chain, E., quoted by Meleney, F. L.: *J. A. M. A.,* 1946, vol. 130, No. 3, 121-123.
2. Ackman, D., Smith, F.: *Ann. Surg.,* 1946, vol. 123, No. 1, 70-95.
3. Allen, H. S., Koch, S. R.: *Surg. Gyn. Obst.,* 1942, 74, No. 5, 914-924.
4. Berkow, S. G.: *Arch. Surg.,* 1924, 8, 138-148.
5. Connor, G. J., Harvey, S. C.: *Ann. Surg.,* 1944, vol. 120, 362-366.
6. Cope, O.: *J. A. M. A.,* 1944, 125, June 24, 536-543.
7. Erb, I. H., Morgan, E. M., and Farmer, A. W.: *Ann. Surg.,* 117, Feb., 1943, 234.
8. Glenn, W. W. L.: *Ann. Surg.,* June, 1944, vol. 119, No. 6, 801-814.
9. Harkins, H. N.: *J. A. M. A.,* 1944, vol. 125, 533-536.
10. Levenson, S. M., Lund, C. C.: *N. Eng. J. Med.,* 1945, vol. 233, 607-612.
11. Levenson, S. M., Davidson, C. S., Green, R. W., and Lund, C. C. As quoted by Lund, C. C., et. al. *Surg. Gyn. & Obst.,* 1946, June, vol. 82, No. 6, 443-478.
12. Lund, C. C., Green, R. W., Taylor, F. H., Levenson, S. M.: *Surg. Gyn. & Obst.,* 1946, June, vol. 82, 443-478.
13. Lund, C. C., and Levenson, S. M.: *J. A. M. A.,* 1943, Oct., vol. 123, 272-277.
14. Meleney, F. L.: *Ann. Surg.,* 1943, vol. 118, 171-186.
15. Meleney, F. L., Johnson, B. A., Pulaski, E. J., and Colonna, Francis: *J. A. M. A.,* 1946, vol. 130, No. 3, 121-123.
16. Pfeiffer, C. C., Hollman, L. F., Gersh, I.: *J. A. M. A.,* 1945, May 26, vol. 128, No. 4, 266-274.

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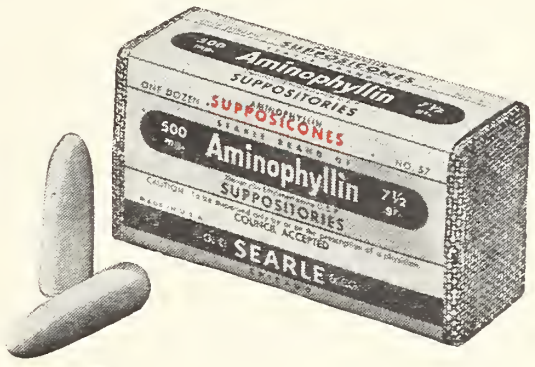
at Westbrook Junior College, Portland, Maine, June 20th to September 12th, 1947

with the distinguished faculty as usual.

The basic subjects covered will be: Anatomy; Embryology; Pathology; Perimetry; Relation of Eye to General Diseases; Motor Neuro Ophthalmology; Biomicroscopy; Optics; Bacteriology; Pharmacology; Biochemistry; together with the clinical subjects: Surgical Principals; Refraction; Glaucoma; Medical Ophthalmology; and Ophthalmoscopy.

For information write Ophthalmological Study Council, 520 Commonwealth Avenue, Boston, Massachusetts.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Abortifacient Action of Penicillin in Pregnancy—Continued from page 24

The small series of six patients included in this report serves as an example of uninterrupted, full-dosage treatment with penicillin in pregnant women. As such, it represents a higher incidence of this complication of penicillin therapy than has been reported in the literature. Two different commercial preparations of the drug were used.

Since Ingraham and his group have observed a lower incidence of such complication from a reduction in dosage of the penicillin during the first 36-48 hours of therapy than was observed by Leavitt and by ourselves in instances in which this precaution was not observed, it would seem, if such comparison can be made, that an initial lowered dosage may be indicated. However, even though initial lower doses of penicillin were used in one patient (case 4), complete abortion resulted.

Theoretically, therefore, the following questions arise: (1) If indicated, should penicillin be reduced below therapeutic doses? (2) Would it not be expected that, if due to uterus-stimulating impurities in the drug, this effect would obtain, in any event, upon commencement of full doses?

Conclusions

1. Two cases of actual and two cases of threatened abortion have been observed in five pregnant women treated for syphilis and in one for bronchiectasis with penicillin in full, uninterrupted, therapeutic dosage.

2. This complication occurred at intervals varying from 18 hours to 3½ days following institution of penicillin therapy.

3. The possibility that this complication may be due to uterus-stimulating impurities in the drug is considered.

4. The administration of penicillin to pregnant women appears to offer the definite possibility of inducing early labor.

Bibliography

1. J. W. Lentz, N. R. Ingraham, Jr., H. Beerman, J. H. Stokes: "Penicillin in the Prevention and Treatment of Congenital Syphilis." *J. A. M. A.*, 126, 408 (Oct. 14), 1944.
2. N. R. Ingraham, Jr., J. W. Lentz, H. Beerman, J. H. Stokes, V. S. Wammock: "Penicillin in the Syphilitic Pregnant Woman." *J. A. M. A.*, 130, 683 (Mar. 16), 1946.
3. M. S. Goodwin, and J. E. Moore: "Penicillin in Prevention of Prenatal Syphilis." *J. A. M. A.*, 130, 688 (Mar. 16), 1946.
4. H. M. Leavitt: "Clinical Action of Penicillin on the Uterus." *J. of Ven. Dis. Information,* 26, 150 (July), 1945.
5. Speiser and Thomas (quoted by Goodwin and Moore): *J. of Ven. Dis. Information,* 27, 20 (Jan.), 1946.

Abdominal-Perineal Wounds—Continued from page 28

damage of the liver and pancreas. Drainage outlined for injuries of the bladder and rectum and stress placed on adequate drainage in these cases.

In injuries of the large bowel colostomy is a must and in diverting the fecal stream a radical division of the bowel in colostomy is necessary.

Chemo-therapy applied locally is not necessary or desired if adequate treatment is given by intra-muscular injection, intravenous or oral methods.

Plasma, blood and various fluids are very necessary in treatment but should be given intelligently and controlled by laboratory aids.

The patients should be carefully observed for any of the common complications and immediate treatment instituted.

No person need be told that he has "a spot on the lung." If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculosis infection—one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginnings of destructive disease, it is, in other cases, the starting point for tuberculophobia and anxiety neuroses, conditions that are no less crippling and hardly more easily curable than tuberculosis itself. Max Pinner, M. D., *NTA Bull.*, Jan., 1945.

The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, March, 1947 No. 3

*The Present Role of Electro-Shock Therapy in the Treatment of Mental Diseases**

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The purpose of this paper is to review briefly the role of convulsive therapy in the treatment of the functional mental disorders, namely, the effective psychoses, schizophrenia and psychoneuroses.

Von Meduna, thinking that schizophrenia and epilepsy were very rarely found associated as coincidental diseases in the same patient, thought that artificially induced convulsions, in cases of schizophrenia, might possibly influence the course of this much dreaded and usually progressive disease entity. Accordingly, after attempting convulsive therapy with several different drugs, he standardized a pharmacological shock treatment which is known as "Metrazol Therapy." Although very encouraging results were obtained with this form of convulsive therapy, there were several objections which have caused it to become more or less outmoded at the present time:

First: Following the injections of the drug, convulsive seizures were not routinely obtained;

Second: And more important: There was a latent period between the injections of the drug and the onset of the convulsion during which the patient experienced marked fear reactions; he had a feeling of impending death and imminent dissolution which caused him to object strenuously to further attempts at this mode of therapy;

Third: It was impossible to accurately regulate the dosage and control the severity of the convulsions.

Cerletti and Bini were able to reproduce this form of therapy by means of electrically induced convulsions.

Electrodes were placed, on either temple, and by the passage of small amounts of alternating current, grand mal seizures were induced at will. The convulsions that followed the introduction of the electric current were instantaneous and entirely without pain or discomfort to the patient.

Patients who are undergoing Electro-Shock Therapy rarely complain of any unpleasantness as a result of the treatment. They recall lying upon a table and having something placed on their temples and then only know that they immediately lose consciousness. Post-convulsively, they complain occasionally of dull, throb-

* Read before The Kennebec County Medical Society, December 19, 1946.

bing headaches or slight nausea, which are easily controlled by symptomatic treatment. Thus, Electro-Shock Therapy has more or less supplanted the pharmacological approach, as the beneficial results obtained from it are comparable to those obtained from metrazol. It also has a much wider range of applicability, both from the relative ease of application of the method and from the patient's point of view. Patients undergoing Electro-Shock Therapy do not dread the therapy as they did the pharmacological approach, and, as a matter of fact, as they show improvement, many realize that "the treatments are of value to them." It is also important to note that complications following Electro-Shock Therapy are only 25% as common as they are following Metrazol Therapy. All cases undergoing convulsive therapy have marked increase in appetite and show decided weight gains, these varying all the way from 4 pounds to 15 pounds in a period of from 2 to 3 weeks.

Although convulsive therapy was originally used as a method of treating schizophrenia, it was soon found that much more beneficial and gratifying results were obtained from its use in the affective disorders, namely, manic depressive psychoses, both in the manic and depressed phase, and in involutional melancholia.

For the purpose of this article, the large series of cases in which Electro-Shock Therapy has been used will not be critically analyzed. One of the disadvantages of critically analyzing statistical results obtained in the different hospitals is that the different schools of psychiatry have different criteria for classifying cases.

If the type of case which is to be treated is not carefully and properly analyzed, it would be impossible to derive reliable statistics, as to the efficacy of this form of therapy in the different types of mental disorders. It is a well known fact that a considerable divergence of opinion may occur between well recognized clinicians as to the diagnostic classification of mental patients, and only the lapse of prolonged period of observation and hospital care will permit the definite determination as to whether a certain patient should be classified as a case of manic depressive psychosis or as a case of schizophrenia. Unfortunately, in the differentiation of these two entities, we do not have laboratory tests at present which will definitely distinguish the two conditions. Difficulty in differential diagnosis, however, is not limited to psychiatry, but is encountered in all medical specialties. It can be seen, therefore, that to envolve accurate statistics on the recovery and remission rates in the different types of mental disorders with Electro-Shock Therapy, one must necessarily consider cases which are absolutely typical in their symptomatology and which do not include cases which may present difficulties in differential diagnosis.

In the affective depressed states, that is, manic depressive psychosis, depressed type, results with Electro-Shock Therapy have been most gratifying. Failures along this line have been markedly low. In Bennett's, Osgood's, and Kalinowsky's material, in fact, failures have been so low as at times to make one doubt the validity of the diagnosis in those instances in which improvement or recovery did not occur.

In the manic phase of manic depressive psychosis, previous failures with this mode of therapy were found to be due to the technique of therapy. Whereas, in the depressed phase of manic depressive psychosis, the frequency of administration of the therapy is every second day, until 6 to 10 treatments have been given, it was found necessary in the manic cases to administer the treatment on 2 or 3 occasions the first day and to give 1 or 2 treatments for the next 2 or 3 successive days before a remission could be obtained.

In dealing with involutional melancholia of the agitated and depressed type, results have been analogous to the satisfying results obtained in the treatment of the depressive states previously mentioned. These good results have been obtained regardless of the length of time patients may have been hospitalized. This fact is particularly encouraging, as many of our mentally ill, who have been hospitalized for from 2 to 8 years in our state institutions, which are always over-populated and pitifully understaffed, should be able, with proper therapy, to be discharged from the hospital in many instances. In the paranoid type of involutional melancholia, however, which all psychiatrists recognize as being a type of mental disorder which is more closely akin to schizophrenia, re-

sults are not as encouraging and are more comparable to those obtained in the schizophrenic cases.

In the psycho-neuroses, as a rule, routine benefit is not obtained from the administration of Electro-Shock Therapy, and, as a matter of fact, some cases may become aggravated with the improper use of this therapy as a result of the temporary confusional states and periods of amnesia which are caused by the therapy itself. The reactive depressions, of psycho-neurotic origin, which at times are difficult to differentiate from the manic depressive type of cases, however, are definitely improved, as are also the anhedonic types and prolonged grief reaction types which have been described by Myerson.

The results in schizophrenia, for which disease condition convulsive therapy was originally introduced, have not been nearly as spectacular or dramatic as those obtained in the affective disorders previously mentioned. It has been the experience of all workers that intensive and prolonged treatment is imperative in this disease entity, or relapses, which are so frequently reported following shock therapy, are certain to follow. Many of the leading authors in this field feel that a minimum of 20 convulsive seizures is necessary to obtain lasting remissions, and many recommend continuation until 30 or 40 treatments have been administered. It is of interest to note that the best results in schizophrenia are obtained in those cases in which the duration of the symptoms of the psychosis has been from less than 6 months to a year.

Remissions and recoveries, in the treatment of this condition, are comparable to the results achieved by the surgeon in the early recognition of carcinomatous lesions; that is, the earlier the therapy is instituted, the greater the number of social recoveries that can be reasonably expected. So it can be seen that it is as important that the signs and symptoms of schizophrenia be detected early, in order to bring about remission, as it is to detect the presence of carcinoma in its early stages if a favorable prognosis is to be expected. In cases of advanced or chronic schizophrenia, even though social recoveries cannot be obtained, in many cases these patients have been found to make more satisfactory hospital recoveries; that is, they come into better contact with their environment, are less of a nursing problem, and in many instances are able, in some way, to assist in the hospital routine. In these cases in which hospital recoveries occur, it has been found necessary to administer treatment periodically, that is, at weekly or monthly intervals, in order to sustain this improvement. The use of Electro-Shock Therapy in this manner is known as "Maintenance Therapy."

It is to be earnestly hoped that in the near future Electro-Shock Therapy machines and properly trained personnel will be found on the chronic wards of all of our well equipped mental hospitals, for it is only by this means, at least in the light of our present knowledge, that the pitiful sight of the dissociated, apparently deteriorated, hallucinated patients, living in a dream world of their own, sitting about in idleness, often destructive and untidy, will be eliminated. It is also morale-building for the medical and nursing staffs of these hospitals, as is so clearly brought out by Kalinowsky, to feel that they have at their disposal a method by which active treatment can be instituted for these patients, thus doing away with the feeling of hopelessness and mere reliance on custodial care, which is practically all that is being offered for these cases at the present time.

From a purely material point of view, it is a definite advantage for a hospital to have this type of therapy at their disposal as these patients become much more self sufficient and because of their improved physical and mental state, are more likely to be of definite value in assisting with the necessary hospital routines, such as working on the farm, in the laundry, cafeteria, etc. It is also to be noted that the saving to the State in the matter of dollars and cents would be very considerable when these cases become less of a nursing problem and are able to be self sufficient and creative in their efforts in the hospital.

One of the most important features of this type of therapy is that through its use, particularly in the affective disorders, commitment to a mental institution may be obviated in many cases. If the suicidally depressed cases, for example, can be adequately protected for a period of a few weeks, complete remissions can

be obtained in a large portion of cases, so that the patient will be able to continue his ordinary pursuits of life, following therapy. The value of preventing the necessity for commitment is quite obvious to all, as unfortunately, the unenlightened laity still attach a stigma to mental diseases which is entirely unwarranted. If the laity would stop to consider that we have approximately 120,000 admissions to mental hospitals per annum and that as the average expectancy of life is at present approximately 60 years, it will be obvious that a child born today in a population of 144,000,000 has about a 1 to 20 chance of being placed in a mental hospital before death. The realization of this fact might well cause them to show much more interest in the welfare and treatment of patients who now reside in our mental hospitals, if for no other reason than that they themselves may some day be so afflicted.

From the few points which have been briefly mentioned in this paper, it is quite evident that Electro-Shock Therapy is not applicable to the treatment of all types of mental disorder. The cases which are selected for therapy should be carefully chosen and evaluated by well-trained psychiatrists, if maximum results are to be obtained. It is necessary to know with what frequency convulsive seizures have to be administered and the number of treatments which may be necessary before reporting the therapy as a failure. It also should be noted that the use of this therapy in cases in which it is not indicated may be detrimental.

The administration of Electro-Shock Therapy is not without complications, as would be expected. However, the fatalities resulting from it are very few. Kolb & Vogel, reporting the result of their survey for American hospitals, found a death rate of only 0.06% from Electro-Shock Therapy. Based on careful study of, and some experience with this type of therapy, this author does not believe that there should be any fatality in the average case. However, Electro-Shock Therapy is used at times in cases where there is known cardiovascular damage, particularly if the course of the mental disease is of such an exhausting nature thus throwing an additional load on an already badly damaged myocardium, that without drastic treatment, the psychosis itself would probably cause death. In these instances, the use of this therapy may prevent almost certain death, but it is to be expected that occasionally the patient will be unable to stand the treatment. Its use in these cases is to be determined by the psychiatrist, from his experience and knowledge of the course of the mental disease involved after consultation with the internist and after the entire situation has been explained to relatives of the patient.

Contra-indications to the use of Electro-Shock Therapy are becoming fewer and fewer as the value of the treatment in mental disorders is more fully appreciated and with more experience in its use. True contra-indications may be stated as acute infectious diseases, advanced pulmonary tuberculosis, aneurysms and organic brain disease in which there are space occupying lesions. Hypertension was previously felt to be a contra-indication for the administration of treatment but is now recognized as not necessarily being one. In fact, in some cases of hypertension, particularly in the agitated depressed states, a lowering of blood pressure has resulted from therapy.

This writer has successfully treated an individual of 65 years of age, with a blood pressure of 220/130, who has been institutionalized for 6 years. Following therapy he was sufficiently recovered to be able to return to his home to enjoy, it is hoped, the remaining years of his life. It must be admitted that it was with considerable trepidation that treatment was instituted in this case, but it was felt that the chances of recovery were sufficient to take the risk involved. Surgeons daily have to operate on poor risk cases when the patient's chances for survival appear slim, and in the last analysis, the psychiatrist has to weigh the pros and cons of the matter and try to arrive at a reasonable conclusion in the treatment of mental cases which are poor risks.

The most frequent complication following Electro-Shock Therapy is sub-luxation of the mandible which may occur even with the experienced therapist if sufficiently firm pressure is not maintained upon the jaw, during the administration of the convulsive seizure. However, such dislocations are usually easily reduced post-convulsively before the patient regains consciousness.

Mild fractures of the thoracic vertebrae have occurred with Electro-Shock Therapy, but these are not sufficiently severe to require orthopedic appliances and the patient recovers spontaneously following one or two weeks bed rest. Fractures of the long bones of the humerus and femur have occurred, particularly in elderly and heavily muscled individuals, and are one of the most embarrassing complications encountered in this type of therapy, although fortunately, these fractures are not frequent.

Before treatment is instituted, in all cases, these patients should be given a complete and thorough physical examination. X-ray of the chest is usually recommended which would serve to exclude pulmonary tuberculosis and aneurysms. It is wise to have lateral X-rays of the spine for two reasons: 1: to determine whether there is any existing pathology present prior to the administration of treatment; 2: for medico-legal reasons.

Electrocardiograms were formerly done routinely in all cases but now are considered to be essential only where there is a history of recent coronary infarct or clinical history or evidence of other cardiac involvement. The psychiatrist should be assisted by the internist in evaluating the physical condition of the patient, particularly in all cases which are considered to be poor risks. However, it is the responsibility of the psychiatrist to determine whether or not therapy should be administered, as he is more familiar with the advantages which may be gained by the administration of treatment.

In conclusion, may I add that in Electro-Shock Therapy, we have a form of treatment which has given very dramatic and encouraging results in some of the carefully selected cases of functional psychoses. One of the most frequent questions asked psychiatrists is: how and why does this form of therapy work in bringing about remissions? Although there have been many theories elaborated as to the mechanisms involved in recoveries following this type of treatment, none of them are entirely satisfactory. It must be remembered, too, that we do not know the etiology of the mental diseases in which we obtain the most beneficial results from this form of therapy; so for the present we must be satisfied with the use of an empirical form of therapy which has definitely shown encouraging results and which is far removed from the experimental stage.

Bibliography

Bennett, A. E.: An evaluation of the shock therapies. *Psychiatric Quart.*, 19:465, 1945.

Bennett, and Wilbur, C. B.: Convulsion shock therapy in involutional states after complete failure with previous estrogenic treatment. *Am. J. M. Sc.*, 208:170, 1944.

Bini, L.: Experimental researches on epileptic attacks induced by the electric current. *Am. J. Psychiat.* (Supp.), 172, 1938.

Cook, L. C.: Convulsion therapy. Recent progress in psychiatry. Ed. by G. W. T. H. Fleming. London, 1944.

Epstein, J.: Electric shock therapy in the psychoses. *J. Nerv. and Ment. Dis.*, 94:115, 1943.

Evans, V. L.: Convulsive shock therapy in elderly patients — risks and results. *Am. J. Psychiat.*, 99:537, 1943.

Kalinowsky, L. B., and Hoch, P. H.: Shock Treatments and other Somatic Procedures in Psychiatry.

Kolb, L., and Vogel, V. H.: The use of shock therapy in 305 mental hospitals. *Am. J. Psychiat.*, 99:90, 1942.

Meduna, L. von: General discussion of the cardiazol therapy. *Am. J. Psychiat.*, 94 (Supp.) 40, 1938.

Myerson, A.: Experience with electric shock therapy in mental disease. *New England J. Med.*, 224: 1081, 1941.

———: Further experience with electric shock therapy in mental diseases. *New England J. Med.*, 227: 403, 1942.

———: Prolonged cases of grief reaction treated by electric shock. *New England J. Med.*, 230:253, 1944.

The results of mass X-ray surveys in discovering unsuspected tuberculosis in apparently healthy persons lead one to the logical assumption that just as much and probably more, tuberculosis might be found through routine roentgenological examination of patients admitted to our general hospitals and clinics. The Mayo Clinic has had such a program for a number of years. At the University of Chicago Hospital and Clinics where this procedure has been followed since 1939, 1.43 per cent of those examined have shown clinically significant tuberculosis. In addition, a large number of non-tuberculous chest conditions were found. The most important among these were malignant neoplasms and cardiovascular disease. The over-all percentage of pathological findings was 21.2 per cent.—Karl H. Pfuetze, M. D., Med. Dir. and Supt., Mineral Springs San., Cannon Falls, Minn.

A Mental Health Program for Maine

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With possibly one or two exceptions Maine is the only state in the entire country in which health and welfare departments are under one administrative head. Since mental health is a public health activity, the division of mental health was set up within the Bureau of Health in the Department of Health and Welfare. It was felt that this should definitely facilitate bringing mental health services to all departments. The general objectives are:

1. To give consultation and treatment service to the divisions within the Department.
2. To acquaint the staff members of the divisions with mental health principles and indirectly give them some training in organization and operation of mental health services for children and adults.
3. To present to the public the principles of prevention of mental disorders.

According to Dr. Victor H. Vogel, Past Assistant Surgeon, U. S. Public Health Service, "we spend fortunes for hospital care of the end products of mental disturbances but only pittances for prevention. Blindly and foolishly we continue to pay $210,000,000 a year of public funds to maintain our mental hospitals, but only about $5,000,000 for the support of mental hygiene clinics to prevent their commitment."

Recent information published by the National Committee on Mental Hygiene predicts that one out of every twenty babies born alive today will be admitted to a mental hospital at some time during its life. In 1943, the American Medical Association reported 651,000 hospital beds in institutions for nervous and mental diseases, more than half the hospital beds in the country. These figures and predictions show the need for state mental health programs.

In the past psychiatric care has not been available to the mass of the population. Today the attention of the whole country is focused on preventive and curative mental health services for all classes. There is a demand for hospital and out-patient services that will come within the means of all. Because of recent popular literature concerning life in a mental hospital, and disclosure of certain unpleasant conditions in institutions, numerous citizen groups have been formed to promote better mental health and better standards for the state hospitals. In 1945, the Committee on Psychiatric Standards and Policies of the American Psychiatric Association drew up certain standards and policies for all mental hospitals and out-patient clinics. I shall not go into the standards regarding mental hospitals. But I should like to briefly mention a few standards for the clinics—(*American Journal of Psychiatry,* Volume 102, 2, pages 264-269, Sept., 1945.)

1. The clinic should accept for consideration persons whom the referring agent felt to be in need of psychiatric help, secure an adequate history regarding the person, determine the type and amount of service needed.
2. The clinic should be able to come to a conclusion regarding the cause of the disorder and interpret the findings to those who would need to coöperate in treatment.
3. In cases of psychiatric disorders a clinic should be able to offer appropriate out-patient treatment or help the patient to secure such treatment.
4. When the clinic is not large enough to act as an all-purpose clinic, it should try to make provision for services through other agencies.
5. An educational program should be one of the functions of a clinic. This can include general public education and professional education of related persons and agencies through work on cases.

Presented at Maine State Conference of Social Welfare, Thirty-Seventh Annual Meeting, November 7, 8, 1946, Lewiston, Maine.

6. Types of service should include consultation, diagnostic study, and report, referral of patient for other types of medical examination and treatment not provided at the clinic, and treatment.

7. The staff should consist of a director who is a psychiatrist, a full-time psychiatrist, a psychologist, two psychiatric social workers and a clerical worker or secretary. The director should give at least half time to clinical work. Services should be by appointment, with one hour allowed for each patient per visit.

These qualifications refer to all clinics whether run in connection with the mental hospital or under the Division of Mental Health.

Before making definite plans it was felt that valuable information could be obtained from an examination of the Mental Hygiene Divisions in New Hampshire and Vermont. These states correspond somewhat to Maine geographically, industrially and socially.

New Hampshire's Mental Hygiene Clinics have been sponsored by the New Hampshire State Hospital. These have been functioning about thirteen years. There are three weekly clinics in different areas, and two monthly clinics. Adults and children are seen in each clinic; the number of adult cases is about 18 per cent of the total case load. At present, there is a director of Mental Hygiene and there is a movement to make the Mental Hygiene Division a separate department, independent of the State Hospital. This will necessitate a separate budget to take care of personnel expenses not provided by the hospital. The hospital at present provides psychiatrists, a psychologist, a social worker and part-time speech therapist and occupational therapist.

Vermont has a Psychiatric Clinical Service established in 1939, under the Commissioner of Public Welfare. Clinics are for the study of children who present behavior problems. A central clinic is at the Vermont State Hospital where children can be sent for study. Other local and traveling clinics give services to nine larger towns and cities throughout the state. There is one full-time psychiatrist and two on a part-time basis. Services are provided to examine children under the care of welfare agencies, dependent, neglected, delinquent children against whom court proceedings have been instituted or are pending. Vermont also set aside a sum of money to start a census of the mental defectives in the State.

In starting a mental health service we want to get the best personnel possible. We expect that the competition will be stiff because the federal government offers more attractive salaries to psychiatrists, psychologists, and social workers to work in the Veterans' Facilities. For a clinic to operate successfully a complete team is necessary. This consists of a psychiatrist, psychologist, psychiatric social worker and stenographer. Clinical service must be made available to the community at regular intervals, preferably once a week. This service is continuous and is necessary for the handling of psychiatric treatment cases which should be one of the main aims of the clinic. Because of the size and the scattering of population, we are aware that one clinic team cannot give continuous service to the entire state. So we must plan to give service to a pretty limited number of people, restrict ourselves to certain areas and work with a special group of patients at first. Therefore, it is planned to set up weekly clinics in Portland and Bangor with a monthly or bimonthly clinic in other districts where special needs may arise. Most clinics under a mental health division emphasize services for children and parents, see relatively few adults. More children can be seen in a year for treatment because individual treatment is for a relatively shorter period in general. Twenty treatment cases a week with an average of an hour per patient per week is the maximum capacity of one psychiatrist.

Such a plan, of course, leaves the less settled and less socially developed parts of the state without clinical service. Perhaps a plan can be made under which the district health nurse and the social welfare worker assigned to such areas can have a period of training, working with the clinic team, and thus become familiar with child guidance methods. Then these persons would be able to recognize the acute problems and provisions for consultation could be made.

Why do we need child guidance clinics? Behavior and emotional disorders in children do not arise suddenly. They are the result of ten-

sions and poor adjustment between the child and the parent. Difficulties have arisen over such things as food, toilet training, a new baby, thumb sucking, etc. Friction develops over these ordinary situations and tension between the child and the parent grows. The child finally shows his inner tension through unacceptable behavior or poor personality traits and he becomes a "problem child." A child is expected to meet not only the demands of physical development but also the requirements of society in learning how to convert his infantile, impulsive behavior into the approved patterns of our present day life. The way in which such demands are made and the way in which deprivations and frustrations are placed on the child offer threats or supports to his mental health. How the child learns to accept obedience to authority, independence, self-discipline, and social adjustments will determine how he will react to problems in adult life. The threats to a child's proper emotional development come from adults — namely parents, relatives, teachers, almost any adult who comes in contact with the child. This is why in treating behavior and personality difficulties we work with the parent as well as the child.

To return to definite plans for the division— mental health clinics are needed for adults. In the past many persons have looked upon any form of mental disability as insanity. To feel the need of or seek psychiatric help was to admit insanity or weakness. Many persons who suffer from sleeplessness, physical symptoms for which their family physician can find no cause, excessive fatigue, worries and fears, and lowered productivity at work have little idea of what the trouble is. They can benefit greatly through being given an understanding of their problems and help in solving them. Alcoholics, drug addicts, sexual delinquents, mental defectives and those suffering from various personality disorders can be included among those who suffer from mental disturbances and are in need of help. Because we will be limited for some time to services for children, due to difficulty in securing adequate and competent personnel, we will provide only a minimum of adult psychiatric service. Perhaps this can be done better and easier through out-patient clinics conducted by the state mental hospitals. At present, the Bangor State Hospital conducts an out-patient clinic for children and adults bi-monthly.

Identification, education and general supervision of the mentally defective in the community should be included in a state program. It has been estimated that about 1 per cent of the national population is mentally deficient. Based on this figure we can expect some 8,000 defectives to be found in the state. I believe this figure is much too low. A large number of these persons will be found to be well adjusted at their social level and will never require institutional care or training. There are also many mentally defective children in the community whose parents will not recognize their defect. Their names are never placed on the waiting list for the state school. If adequate home training is not supplied, these children will be candidates for admission to a state school later on. I have no idea how many mental defectives are now going to public schools. From the number of questions I receive from school superintendents, I suspect that the number is rather large.

In order to provide for future care, education and social training of this type of individual, we should have some means of registration. Massachusetts has a central index of the mentally deficient. This has proved of great value in outlining a state program. Cases of mental deficiency are reported by state hospitals and state schools, by traveling school clinics, by child guidance clinics, habit clinics, by juvenile delinquent examinations. The material gathered gives much statistical information which can be reported, but the name of any person so registered is never made public.

Identification of the mentally deficient in the school system is important. Many high-grade morons present a normal appearance and express themselves so well that the defect is not suspected until there are repeated school failures. Too frequently low-grade defectives get into a school system, are unable to progress even in the first or second grade, and finally become a definite problem. When there are ten or more mentally deficient children three years or more retarded in a school system, a special class is indicated to provide for their education and training. These classes serve to remove the backward children from the regular classes

where they interfere with teaching of the normal children and at the same time place the backward children in a group whose mental endowment is more nearly that of their own.

So we have plans for the establishment of a traveling school clinic which will give diagnostic service to the entire state. We would not expect to contact all the retarded children in the schools but we could try to take care of the outstanding problems at first. Later, we would include behavior and other school problems. In Massachusetts such clinics work out of the mental hospitals and state schools. It might be well to consider the possibility of working out some similar program with our state hospitals. This, of course, would depend on the hospitals having sufficient staff to supply a psychiatrist and psychologist for clinic work.

The present tendency is to keep the mentally deficient child in the community, after a short period of training in state schools, to supply home care and training, using institutional care and training for those of very low intelligence or those whose behavior and emotional control is so poor that they must be segregated. New Jersey has such a program which has been going on for three years and is working out well. The parents are given instruction in habit training and an understanding of their child's needs. This type of instruction could be given through community talks and teaching clinics for parents and children.

Part of any mental health plan should be the training of personnel. First, we shall try to provide exposure to and indirect training in methods, procedures, accomplishments and limitations of mental health services to staff members of the other divisions included under the Department of Health and Welfare. This is being done through consultations and discussion of cases with the Division of Child Welfare, Bureau of Social Welfare, Division of Dental Health, Maternal and Child Health Services, Services to Crippled Children, Division of Public Health Nursing, and with the Department of Education. We must also provide training within the clinics for new personnel, trainees and affiliates from other departments, institutions and schools. To do this the clinic must meet the standards I mentioned earlier, set up by the American Psychiatric Association.

I shall not take up the training of personnel for institutional work because I hope Dr. Sleeper will have something to say to you on that subject. However, there should be cooperation between state mental hospitals and mental health clinics so that the facilities of each can be used by the other for training future personnel. Likewise, I shall not say anything concerning research, which is an important part of any mental health set-up, because I hope Dr. Sleeper will discuss this, too. We do plan to keep as good records as possible so that full information concerning each case will be available for future reference and statistical purposes.

We are fully aware of the difficulties that will be encountered in getting such a program under way. Much ground work has to be done before actual operation of clinics can be undertaken. An adequate and competent staff must be secured. Here we are up against the same situation that other departments are faced with — shortage of trained personnel. The division is fortunate in being under the supervision of two far-sighted and understanding men, the Commissioner of Health and Welfare and the Director of Health, who recognize the problems of administration and finance that will be encountered. Our plans extend over the next two or three years, and, without doubt, some changes will be made before the division will be operating on a full-time basis.

At present we are providing a diagnostic and consultation service for the Pediatric and Crippled Children's Clinics. I attend the six or seven monthly clinics held in different parts of the state and examine children referred to me. We are also giving some service to the Department of Education, examining a small number of school children who present difficult problems in school. We occasionally examine a delinquent child. I have taken on a very limited number of treatment cases—both children and adults. Education of the public in the principles of mental health is being done through talks to community groups, teachers, parent-teacher associations, community health and welfare groups, nurses and physicians.

Pathology of Malaria

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It would be convenient to divide the pathology of malaria into the clinical pathology and the pathologic anatomy; the former dealing with the patient's present and future, the latter with his past. Human malaria is caused by parasites belonging to the family of Plasmodidae, several of which are pathogenic: (1) Plasmodium vivax, producing vivax malaria, having a 48-hour asexual cycle in the human host; (2) Plasmodium malariae, producing quartan malaria, having a 72-hour asexual cycle; (3) Plasmodium falciparum, producing falciparum malaria, having a 24 to 48-hour asexual cycle; (4) Plasmodium ovale, causing ovale malaria, having a 48-hour asexual cycle.

In order to have a better understanding of the pathology of this disease, it would be best to describe briefly the life cycle of this parasite. Three factors must be present in the production of this disease. There must be the infected individual, the insect vector, which is the female anopheles mosquito, and the susceptible human. The Plasmodia have an erythrocytic and exo-erythrocytic stage. The latter is found in the mosquitoes and in the reticuloendothelial system of patients. The asexual stage occurs in man and the sexual stage of the life cycle is initiated in man and concluded in the mosquito. The infected mosquito contains the sporozoites (infective form of parasite) in its salivary gland. When the anopheles mosquito bites the individual, it introduces the sporozoites into the blood. The sporozoites are next seen in the blood after a latent period of several days (5-14) as ring forms in the red blood cells. This period, where they are absent, is called the cryptozoite stage and it is thought that they are in the reticuloendothelial system multiplying. The ring forms are part of the trophozoite stage; following this the parasites become dividing forms (Schizonts). The parasites rupture the red cells, invade new red cells and the cycle begins anew with the ring forms. The cause of the chill is unknown but is believed to be coincident with the rupture of the red cells. After schizogony has continued for a certain period of time, some trophozoites change into sexual forms (gametocytes). Plasmodium vivax is capable of maintaining itself in a patient for a period of three years hidden in the exo-erythrocytic regions (within the cells of the reticuloendothelial system). Within these cells they may be the source of trophozoites and also of gametocytes which may later appear in the circulating blood and thus be responsible for the relapses.

The sexual cycle takes place in the female anopheles mosquito. Gametocytes, which are in sufficient numbers and proportions of males and females, are sucked into the stomach of the mosquito when she has her blood meal. Gametes are formed and then a zygote which is followed by an ookinete. The latter migrates through the stomach wall and becomes an oocyst which ruptures, liberating sporozoites into the body cavity. From this site the parasites migrate to the salivary glands and the mosquito becomes infective.

The diagnosis of malaria is frequently difficult. Definitive diagnosis depends upon the demonstration of the parasites. For this purpose two methods are used routinely, the thin film and the thick blood film techniques. In making the thin film, one uses the method of spreading blood on a clean glass slide as when doing a differential smear of blood. The blood is stained with Wright's stain. This method is rapid and a diagnosis can be made rapidly if there are many parasites in the red cells. In many cases of light infections the thin film is negative. The thick blood is far superior to the thin film technique and will yield three to four times as many positive findings and reveal the plasmodia in 90 to 95 per cent of the active clinical cases. This method, however, is more difficult of interpretation and requires experienced technicians. The method of preparing such a film is as follows: Take several average size drops of blood quite near each other on the slide, then with a needle or with the corner of a clean slide quickly puddle these into one homogeneous drop about the size of a dime. Ordinary printing can be just read through the wet center of a well made thick film when the

slide is placed over a printed page. A covered Petri dish may be used for drying the slides in order to protect it from flies and cockroaches which will eat away the blood or contaminate it with bacteria or other organisms. To aid in quick drying, the slide may be placed for a short while in an incubator at 37° C. In staining the thick film the best results are obtained from using Giemsa's Stain. The stock solution consists of: Powdered stain 1.0 gms; Glycerin (C. P.) 66.0 cc.; Methyl Alcohol, absolute, acetone free 66.0 cc. The smear is placed in diluted stock Giemsa, 1 cc. to 50 cc. buffered water pH 7.0, for 45 minutes. It is then washed quickly in buffered distilled (or tap) water and stood on end to dry. The thick films are automatically laked in the aqueous dilution of the stain.

Other characteristics of the stained thin blood films may be of help in the diagnosis. In malaria, the patients may show a hemolytic type of anemia, leucopenia with a relative increase of monocytes. Leukocytes containing ingested malarial pigment are rarely seen except in heavily infected cases. Leukocytosis may occur during a chill. In some cases where it is impossible to demonstrate the parasites in the thick film, subcutaneous injection of 0.5 to 1 cc. of 1-1000 adrenalin may be followed by the appearance of the plasmodia in the blood. Four or five smears may be made thereafter at intervals of 15 minutes.

Fortunately, in the vast majority of symptomatic malarial infections, the plasmodia may be demonstrated in either thin or thick films, so that it is rarely necessary to employ other diagnostic methods. It is in the latent malarial infections that we sometimes find it impossible to demonstrate the plasmodia in the peripheral blood and dependence must be placed upon some other method of diagnosis. Sternal puncture and puncture of the spleen or liver are methods that have been used. Of the three mentioned, sternal aspiration is the safest and is preferred. Cultivation methods are of little use in the diagnosis of malaria and are rarely used for this purpose. Serological reactions have yet to prove their practical value in the diagnosis of malaria. Complement fixation and precipitin tests have been used but neither of the two methods are employed in the routine diagnosis of malarial infections. The fact that these serological tests are positive in conditions other than malaria, renders the diagnosis of malaria based upon these tests above, open to question.

There are about three hundred million cases of malaria in the world, annually, with a one per cent mortality rate. Death occurs in uncomplicated falciparum infections, but in vivax and quartan infections death is due to complications. In malaria the reticuloendothelial system is important. Immunity is based in the spleen, liver and bone marrow. Changes are found there because of the strategic position of phagocytic cells in relation to the blood stream. In cases of death due to falciparum malaria, the spleen is enlarged, presenting a dark, sometimes black, surface (Ague caked spleen). The liver is often enlarged and presents a cloudy swelling. Histologically, the changes are characterized by a finely granular, dusk-like pigment in the spleen and in the liver. The reticuloendothelial cells show a diffuse hyperplasia and parasitized erythrocytes are seen. The bone marrow contains parasites and malarial pigment. The brain shows ring hemorrhages, malarial granulomas and the presence of parasitized red cells and pigment. The capillaries of the heart contain pigmented phagocytes and parasitized red cells. Interstitial edema is present. Gastritis and enteritis are found due to the presence of parasites in the swollen capillaries of the mucosa. In the placenta, parasites are not found in the cells of the chorionic villi. However, the maternal sinuses are filled with parasites and phagocytosed pigment. In the complications of malaria, spontaneous rupture of the spleen is seen. Bronchopneumonia, virus pneumonia, glomerulonephritis, adrenal insufficiency and black water fever are other complications. Black water fever is a hemoglobinuric nephrosis. It occurs chiefly in patients who are RH negative. In the course of repeated falciparum infections, RH positive factors are thought to develop and this results in iso-immunization with the subsequent development of a hemolytic anemia.

It has long been known that the Wasserman and Kahn serological tests are positive in many cases of malaria. In the cases of vivax malaria seen at this hospital, we have found many cases with a positive Kahn and Wasserman reaction.

Continued on page 72

The President's Page

The Difference of Viewpoint

At present we are trying to have a Medical School established in the State of Maine.

From the viewpoint of the Maine Medical Association it is not a selfish motive at all but an altruistic one. The Medical Association well recognizes the great need for more and better medical service in our rural communities.

We contend that no other organization of individuals in the world has done more to aid humanity nor has tried harder to make their services stay within the reach of everyone than has the medical profession.

The rural physician has given freely of his services to the poor and needy. Oftentimes he has met an early death due to the tremendous amount of exposure to which he has been subjected combined with loss of sleep and rest.

We know that the cost of building and maintaining a medical school in Maine would be great, but if we have a few more medical men going into our rural communities, each year the benefits would be increasingly evident and the resultant percentage of lives saved plus the additional comfort given to innumerable suffering individuals would by far offset the cost of the school.

We have never seen any great hesitancy in conducting various investigations of, say, "Liquor Traffic" or "The Reasons for Plane Crashes," which have after all killed relatively few people. We could go on and enumerate many more so-called investigations which have run into many millions (how easy we say it) more money than the Maine Medical School would ever cost.

We contend that the results of these investigations have not yielded so very much to suffering humanity.

We believe that if an honest comparison as to actual results as far as the good accomplished were made between the cost of erecting and maintaining a medical school in Maine and the good and benefits derived from these so-called investigations, there would be no doubt which would receive the greater vote.

John O. Piper, M. D.,
President, Maine Medical Association.

Editorial

U. S. Health Department Bills Need Watching, Journal Warns

Pending legislation in Congress to create an executive department of the government to be known as the Department of Health, Education and Security "will demand close attention by the medical profession," according to an editorial in the February 8 issue of *The Journal of the American Medical Association.*

"Essentially," *The Journal* states, "it would seem that the effect of this legislation would be to transform the Federal Security Agency with its various and not too closely related functions into an executive department with relocation of the several functions of that agency."

The Journal's editorial says in full:

A brief editorial reference was made in *The Journal* January 18 to pending legislation in Congress, introduced by Senator Fulbright and Senator Taft as S. 140, to create an executive department of the government to be known as the Department of Health, Education and Security. A similar bill is pending in the House, H. R. 573, introduced by Representative Harris, Arkansas. This proposal is of much importance to American medicine.

At the head of the new department would be a Secretary of Health, Education and Security appointed by the President by and with the advice and consent of the Senate. The qualifications to be possessed by the secretary are not stated. In the department there would be three main divisions, each under the immediate supervision of an Under Secretary, a Division of Health, a Division of Education and a Division of Security. The Under Secretary of Health would be a doctor of medicine licensed to practice medicine or surgery in one of the states or territories of the United States or in the District of Columbia, and would perform "such duties concerning health as may be prescribed by the Secretary or required by law." Thus, apparently, the duties of the Under Secretary of Health, who must be a doctor of medicine, will in part be prescribed by the secretary of the department, whose qualifications are not set forth in the bill. Too, one section of the bill would authorize the secretary to delegate to any officer, board or employee of the department any of his functions, powers and duties except that the function of promulgating or approving regulations may be delegated only to an under secretary. Presumably this authority to delegate functions includes the right to delegate the prescribing of the duties to be performed by the Under Secretary of Health.

Provision is made for the appointing by the secretary of advisory committees to advise and consult with him, the membership of which must include such persons not otherwise employed by the federal government as in his judgment are most representative of voluntary organizations operating in the respective fields with relation to which such committees may be appointed.

Generally stated, the new department would be authorized to promote the general welfare by aiding and fostering programs in the field of health, education and security, and related services contributing to individual, family and community well being. These objectives would be carried out, it is contemplated, to the "fullest possible extent through state and local agencies, public and voluntary, and in such manner as to preserve and protect to the highest possible degree the independence and autonomy of state

and local agencies, public and voluntary, in education, health, security and related fields."

Specifically, the department would be authorized to:

(a) aid, stimulate and encourage the development throughout the nation of services and facilities, both public and voluntary, in the fields of health, education, security and related fields;

(b) promote, foster and encourage state, community and voluntary activity in those fields;

(c) advise and coöperate with other departments and agencies of the federal government, with state governments and agencies and with voluntary agencies functioning in those fields:

(d) collect and analyze statistics and make studies, investigations and reports on conditions, problems and needs in those fields in the United States and in other countries, and disseminate and make available information in those fields;

(e) make reports and recommendations with respect to the most effective policies and methods for the promotion of health, education, security and related services, including recommendations with respect to legislation and matters of administrative policy;

(f) advise and coöperate with international organizations functioning in those fields; and

(g) administer such federal programs, including grants-in-aid, and such powers, functions and duties in those fields as are assigned to it or provided through this or subsequent legislative enactment.

The office of the federal security administrator and the Federal Security Agency, and its constituent units, together with all their functions, would be transferred to the department and, subject to the exceptions noted, would be allocated, distributed and administered under the direction and supervision of the secretary, who would be authorized to abolish such office and agency and any such unit in the interest of administrative efficiency.

To the Division of Health would be specifically transferred the U. S. Public Health Service, the Freedmen's Hospital, the Food and Drug Administration and the Federal Board of Hospitalization. To the Division of Security, the under secretary of which will be a person experienced in the field of social security and welfare, will be transferred the Committee on Economic Security and the Children's Bureau. The Office of Education and the functions of the Federal Security Agency relating to the administration of Howard University and the Columbia Institution for the Deaf will be transferred to the Division of Education.

Essentially, it would seem that the effect of this legislation would be to transform the Federal Security Agency with its various and not too closely related functions into an executive department with a relocation of the several functions of that agency. While the House of Delegates has repeatedly urged that a national department of health be established, it has recognized the dangers incident to the mingling in one department of health and other functions. At a special meeting held in 1937 at a time when the reorganization of governmental activities in the executive departments was under consideration, the Board of Trustees prepared a statement expressing the opinion that "health activities of the government, except those concerned with the military establishments, should not be subservient to any other departmental interests." This action of the Board of Trustees was approved by the House of Delegates at its meeting in Atlantic City in June, 1937.

The pending bill, if enacted, might serve to bring about such subserviency; its consideration by the Congress will demand close attention by the medical profession.

Report of Delegate to the American Medical Association

In accordance with a vote of the House of Delegates of the American Medical Association at the July, 1946, meeting, another meeting of the delegates was held in Chicago Headquarters, in December, 1946. One hundred and sixty-seven delegates from the constituent societies answered the Roll Call. At San Francisco, in July, the delegates realized that in order to keep abreast of the important business which was presented to the House for consideration, it would be expedient to hold a meeting before the annual meeting in June, 1947, at Atlantic City. Your delegate favored the resolution proposing the extra meeting and suggests here and now, as he has before, that the Maine Medical Association would do well to adopt the plan.

The principal business before the delegates was to consider the Rich Report. The special committee of which Dr. William Bates, of Pennsylvania, was Chairman, presented the full report in Executive Session with the delegates sitting as a Committee of the Whole. The Rich Report of forty-five pages was prepared by Raymond Rich and Associates, Public Relation Counsellors.

The conclusion reached by Mr. Rich included this statement, "To separate distinctly the functions of scientific interpretation, medical economics and social medicine, and the direction of public relations." After free discussion the above recommendations were approved. Dr. George Lull, the Secretary and General Manager, will serve as general supervisor. Dr. Morris Fishbein will carry on as editor of the scientific publications. The Council on Medical Services will continue its functions and will intensify its efforts toward the extension of voluntary prepayment plans. And a full time public relations officer has been appointed to direct the Department of Public Relations.

The Trustees are endeavoring to carry out the recommendations approved by the House of Delegates, recommendations which are intended to perfect the work of the various departments.

The relationship between the N. P. C. and the A. M. A. was disapproved by the Rich Report. In-as-much, as the House of Delegates have unanimously endorsed, at previous meetings, the efforts of the N. P. C. and of other organizations with like objectives, this recommendation to sever connections was referred to a special committee for study and report at the annual meeting in June.

It is evident to your delegate that sincere efforts are being made by the members in the House of Delegates to fashion the great body of American physicians into a genuinely effective organized group. Radical changes do not seem necessary, evolutionary progress to meet the increasing functions of the Association seem definitely underway.

The reports of the various Councils and Bureaus indicate a healthy condition. Improved bulletins and pamphlets are being planned. Enlarged bureaus are being organized. The Council on Medical Service is crystalizing voluntary prepayment medical plans. And your delegate must report that he gained the impression that such plans are growing stronger in all parts of the Country. Maine is one of the few states without a plan. The decision of our President and Council to petition this Legislature for an enabling act seems to the writer a wise one. The impetus behind the Wagner-Murray-Dingell Bill has been lessened by the last election but the forces behind it still remain in positions of importance in Washington.

The delegates were given a preliminary report of the Program for the annual meeting of the Association in Atlantic City next June.

This will be the 100th Anniversary Meeting and it will be an unusually interesting one. Renowned national and international figures in medicine will address the gatherings. Special historical features will be presented. The brilliant accomplishments of the men in medicine will be recounted for the world to read and applaud. It will, indeed, be a meeting for all practitioners to attend. May I, at this time, advise our members to make plans accordingly.

Thomas A. Foster, M. D.,
Delegate.

Clinico-Pathological Conference, Eastern Maine General Hospital, Bangor

Roy Crosby, M. D., *Presiding*

Edited by Joseph E. Porter, M. D., Portland

Patient: White, male, age 72, American.

Present Illness: Four days before admission, said to have had a severe chill followed by fever. Two days before admission had another chill accompanied by partial "rigor." Admitted to hospital slightly disoriented and unable to give a history of his illness. Complained bitterly when left shoulder was moved or touched.

Physical Examination: Elderly male, well developed and well nourished, lying quietly in bed in a stuporous state. Pupils round and equal and reacted to light. Tongue coated and breath foul smelling. No heart murmurs heard. Occasional extra systoles. Lungs clear anteriorly and laterally. Entire abdomen tender; no masses palpable. Left shoulder warm to touch and slightly swollen. Patient complained bitterly when shoulder was moved. No edema or cyanosis. Positive Babinski sign on left; slightly positive on right. Oppenheim and Gordon present on left; Oppenheim on right. No obvious facial weakness noted. Blood pressure 145/82 mm. Hg.

Blood: N. P. N., 63 mg. per 100 cc. Hb. 13. gm. (83%); R. B. C. 3,980,000; W. B. C. 5,000; Polys. 56%, Bands 33%, Lymphs 6%, Monocytes 5%.

Urine: Sp. gr. 1.012; heavy trace of albumin; many coarsely granular and occasional hyaline and finely granular casts; some epithelial cells; occasional white and red blood cells.

Lumbar puncture on second hospital day showed initial pressure of 180 mm. water.

On second hospital day, N. P. N. was 76 mg. per 100 cc. Agglutination tests for Typhoid O and H, Paratyphoid A and B, B. abortus and Proteus OX19 were negative.

On the third hospital day the N. P. N. was 97 and on the fourth day, 126 mg. per 100 cc. It rose on the day of death (5th hospital day) to 144 mg. per 100 cc.

The temperature rose to 105.2° F. by rectum on the day of admission and subsequently remained around 102.0° F. by rectum. The pulse remained around 100 until the day before death when it dropped to 70 per minute. Respirations remained around 30 after the first hospital day.

X-ray: On day of admission, chest showed moderate increase in root density and soft increase in bronchial markings in both lung bases. No bone or soft tissue pathology was made out about the left shoulder girdle.

Patient was given repeated clyses of glucose and water. Penicillin was administered every 3 hours. On the third hospital day the patient perspired freely and became unresponsive and noisy. On the fourth hospital day, a Foley bag was inserted because the patient had not voided for 9 hours. On the morning of the 5th hospital day, he vomited 3 drams of brownish fluid with mucus. The pulse became weak and respirations labored. Patient expired.

Discussion

Dr. Jay Moses: There is no report of a blood culture. I would like to know if one was taken; also the findings other than the pressure of the spinal tap.

Dr. Richard C. Wadsworth: Blood culture taken two days before admission was negative. The spinal fluid showed a cell count of one and no reduction of colloidal gold.

Dr. Moses: We, of course, have no past history nor are we very clear about the onset of this illness other than the chills. The picture on admission is one of an overwhelming infection as witnessed by the stuperous condition, high fever, and lack of leukocytic response in the face of a very definite shift of the polymorphs to the left. Neurological signs were present which leads one to strongly suspect that the lateral cortico-spinal tracts were involved and

probably higher centers as well. The continued and rapid rise of the non-protein nitrogen and the termination of the illness in uremia, coupled with the urinary findings of low specific gravity, albuminuria, and casts and blood cells, lead me to suspect that there may have been an underlying kidney damage. Superimposed upon this, the terminal illness made for the rapid exodus in uremia. We have, however, only one blood pressure reading, this while the patient was semi-comatose, and no knowledge of his usual pressure. The present reading is not markedly elevated but does not, in my mind, serve to rule out previous kidney damage.

The warm, painful, swollen shoulder is a matter for speculation. We were told that there was also swelling of the left hand. X-ray examination of the shoulder fails to enlighten us.

What then are the conditions that might be present in the kidneys?

1. An old low grade glomerulo-nephritis perhaps? This is usually brought to the clinical level at age 40 to 60, when arteriosclerosis further embarrasses the kidneys. This patient is a little above the age group for this.

2. Tuberculosis of the kidneys with a possible military spread seems to be eliminated by the chest picture.

3. Polycystic kidneys (congenital) may have given an underlying embarrassment of function.

This brings us to the point where we must try to make some condition fit the symptoms. If this is a septicemia, we do not know its portal of entry. One condition which might account for the symptoms is a shower of infected emboli. From what source? Perhaps from an endocarditis. The organism, of course, was not found in the blood culture reported. Most commonly in endocarditis, the streptococcus, or less frequently a staphylococcus are the infecting organisms. There was only an occasional pus cell in the urine which would seem to make a staphylococcus less likely. Pneumococcus is also a possible organism. The chest plate shows what seems to be broncho pneumonia though admittedly very little can be made out from the portable film.

The cardiac symptoms are admittedly minimal though they sometimes are in endocarditis. No definite meningeal signs are present though central nervous system signs are present.

As a final diagnosis, I can only repeat the speculations in the order in which they seem to fit:

1. Underlying kidney pathology—glomerulonephritis or polycystic kidneys, with the favor on the latter, and either with accompanying arteriosclerosis.

2. Endocarditis with infected emboli lodging in left shoulder joint, hand, brain, spinal cord, and the kidneys with multiple infarcts.

3. Broncho pneumonia.

In the literature it has been reported that in necropsies on patients dying from endocarditis with embolic phenomena, 76 per cent had kidney infarcts. In necropsies in which kidney infarcts were noted, as high as 95 per cent had underlying cardiac lesions.

Anatomical Diagnoses
(Dr. R. C. Wadsworth)

Acute bacterial endocarditis (aortic and mitral valves).

Septic mural thrombus, right auricle.

Lobular pneumonia, right lower lobe, with abscess formation.

Healed pneumonitis, left lower lobe.

Bilateral pulmonary congestion and edema.

Acute toxic splenitis.

Chronic cystitis.

Chronic bilateral pyelonephritis.

Multiple septic infarcts of brain.

Generalized arteriosclerosis, with coronary sclerosis and arteriosclerotic nephrosclerosis.

Dr. Wadsworth: The present illness probably started with a lobular pneumonia, followed by septicemia, an acute endocarditis involving mitral and aortic valves, and multiple septic infarcts of the brain. The chronic cystitis and pyelonephritis undoubtedly antedated the pneumonia. The kidney reserve was probably previously diminished by the marked nephrosclerosis. Uremia was probably the immediate cause of death.

COUNTY SOCIETIES

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County Society Notes

100% Paid Membership for 1947

Piscataquis County Medical Society
Waldo County Medical Society
Hancock County Medical Society

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Wednesday, February 12, 1947, at 6.30 P. M.

Dr. Norman E. Cobb, of Calais; Dr. Martyn A. Vickers, of Bangor; and Dr. Seth H. Read, of Belfast; were guests at the meeting.

Dr. M. A. Torrey, of Ellsworth, was elected Vice President of the Society.

Mr. L. B. Hinckley, Jr., representing the Trustees of the Eastern Memorial Hospital, reported the plans and progress made by his group toward building the proposed new hospital.

The members present discussed the present schedule of fees for treating compensative cases. It was felt that these fees are not adequate in some instances. The county delegate was instructed to bring the Society's views before the House of Delegates of the Maine Medical Association at the June meeting.

George W. Holmes, M. D., of Belfast, gave a very interesting paper on "Recent Advances in the Roentgen Diagnosis of Lesions in the G. I. Tract." The paper was followed by a discussion period.

J. H. Crowe, M. D.,
Secretary.

Lincoln-Sagadahoc

A meeting of the Lincoln-Sagadahoc County Medical Association was held February 24, 1947, at the Bath Memorial Hospital, Bath, Maine.

Eighteen members were present and enjoyed a delicious dinner served by the hospital kitchen staff.

Gilbert Clapperton, M. D., of the Central Maine General Hospital, Lewiston, Maine, gave a very interesting discussion on "Anesthesiology and Oxygen Therapy."

John F. Dougherty, M. D.,
Secretary.

Penobscot

A regular meeting of the Penobscot County Medical Association was held at the Bangor House, Bangor, Maine, on February 18, 1947, at 6.30 P. M.

Donald E. Bridges, M. D., of Winterport, was elected to membership in the society.

W. L. Fleming, M. D., of the Massachusetts Memorial Hospital, Boston, was guest speaker. His subject was "Recent Advances in Treatment of Syphilis and False Reactions."

There were forty-two members and three guests present.

J. Eldrid Smith, M. D.,
Secretary.



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Piscataquis

E. Delmont Merrill, M. D., celebrated his 82nd birthday on February 22nd, 1947, two days prior to his actual birth date, by entertaining the members of the Piscataquis County Medical Association and their wives at supper at his home in Dover-Foxcroft.

Edwin T. Wyman, M. D., of Boston, read a paper on "Pediatrics." This was one of the most instructive papers ever read to our Association, and I hope that it will be published in The Journal of the Maine Medical Association so that anyone who reads the Journal may profit by it.

N. H. Nickerson, M. D.,
Secretary.

New Members

Knox

Lyman C. Burgess, M. D., Camden, Maine. (By transfer from the New Hampshire Medical Society.)

Penobscot

Donald E. Bridges, M. D., Winterport, Maine.

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HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

News and Notices

American College of Surgeons Sectional Meeting—March 28-29, 1947

There is to be a sectional meeting of the American College of Surgeons at the Providence Biltmore Hotel, Providence, R. I., Friday and Saturday, March 28th and 29th, 1947, to which the Profession is cordially invited. An excellent program has been provided, divided into two parts; one on Surgery and one on Hospital Problems. It is hoped that there will be a large attendance from our State.

Industrial Health Meetings April 26 Through May 4, 1947

A conclave of combined professional personnel in industrial health work over the entire nation will take place at the Hotel Statler, Buffalo, N. Y., April 26 through May 4, 1947.

These meetings will represent the 32nd annual gathering of the American Association of Industrial Physicians and Surgeons; the 9th annual conference of the American Conference of Governmental Industrial Hygienists; the 8th annual meeting of the American Industrial Hygiene Association; the 5th annual conference of the American Association of Industrial Nurses; and the 4th annual meeting of the American Association of Industrial Dentists.

Further details and a copy of the preliminary program may be secured by writing to Dr. Edward C. Holmblad, Managing Director of the American Association of Industrial Physicians and Surgeons, 28 East Jackson Blvd., Chicago 4, Ill.

The American Society for the Study of Sterility

3rd Annual Convention—June 7-8, 1947

The third annual convention of the American Society for the Study of Sterility will be held at the Hotel Strand, Atlantic City, New Jersey, on June 7 and 8, 1947. The general theme of the meetings will be that of attempting to disseminate to the physician treating marital infertility an over-all picture of the latest advances in reproduction.

Additional information may be obtained from the Secretary, Dr. John O. Haman, 490 Post St., San Francisco 2, California.

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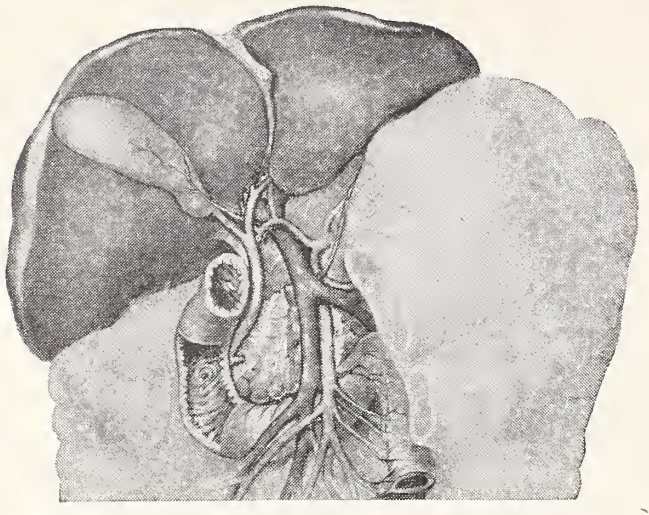
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McLaughlin, Secretary of the Millinocket Central Labor Union.

Mr. McLaughlin states in his letter "that there is a fine opportunity for at least one more competent medical doctor." There is a paper mill which employs about 850, a small private hospital, and they are in hopes of having a small hospital unit (perhaps about 30 beds) built under the Federal Hospital Building program.

For further information write to Mr. Albion McLaughlin, Secretary, Millinocket Central Labor Union, Millinocket, Maine.

Bureau of Health

State Services for Crippled Children Clinic Schedule, 1947

Portland—Children's Hospital, 9.00-11.00 a. m.: Jan. 13, Feb. 10, Mar. 10, Apr. 14, May 12, June 9, July 14, Aug. 11, Sept. 15, Oct. 13, Nov. 10, Dec. 8.

Lewiston—Central Maine General Hospital, 9.00-11.00 a. m.: Jan. 24, Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 29, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Rumford — Community Hospital, 1.30-3.00 p. m.: Apr. 16, June 18, Aug. 20, Oct. 15, Dec. 17.

Waterville—Thayer Hospital, 1.30-3.00 p. m.: Feb. 27, Apr. 24, June 26, Aug. 28, Oct. 23, Dec. 18.

Rockland—Knox County Hospital, 1.30-3.00 p. m.: May 15, Aug. 14, Nov. 13.

Machias—Normal School, 1.30-3.00 p. m.: Apr. 9, July 16, Oct. 22.

Presque Isle — Northern Maine Sanatorium, 9.00-11.00 a. m.: Jan. 7, Mar. 5, May 6, July 9, Sept. 9, Nov. 5.

Houlton — Aroostook General Hospital, 9.00-11.00 a. m.: Mar. 4, July 8, Nov. 4.

Fort Kent — Normal School, 9.00-11.00 a. m.: Jan. 8, May 7, Sept. 10.

Bangor—Eastern Maine General Hospital, 1.30-3.00 p. m.: Mar. 27, May 22, July 24, Sept. 25, Nov. 20.

Portland — Cardiac, Maine General Hospital, 10.00-12.00 a. m.: Will be held every Friday with the exception of holidays (May 30, July 4, and Dec. 26).

State Pediatric Clinic Schedule, 1947

Bangor — Eastern Maine General Hospital, 1.30 p. m.: Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 22, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Waterville — Thayer Hospital, 1.30 p. m.: Jan. 7, Mar. 4, Apr. 1, May 6, June 3, July 1, Aug. 5, Sept. 2, Oct. 7, Nov. 4, Dec. 2.

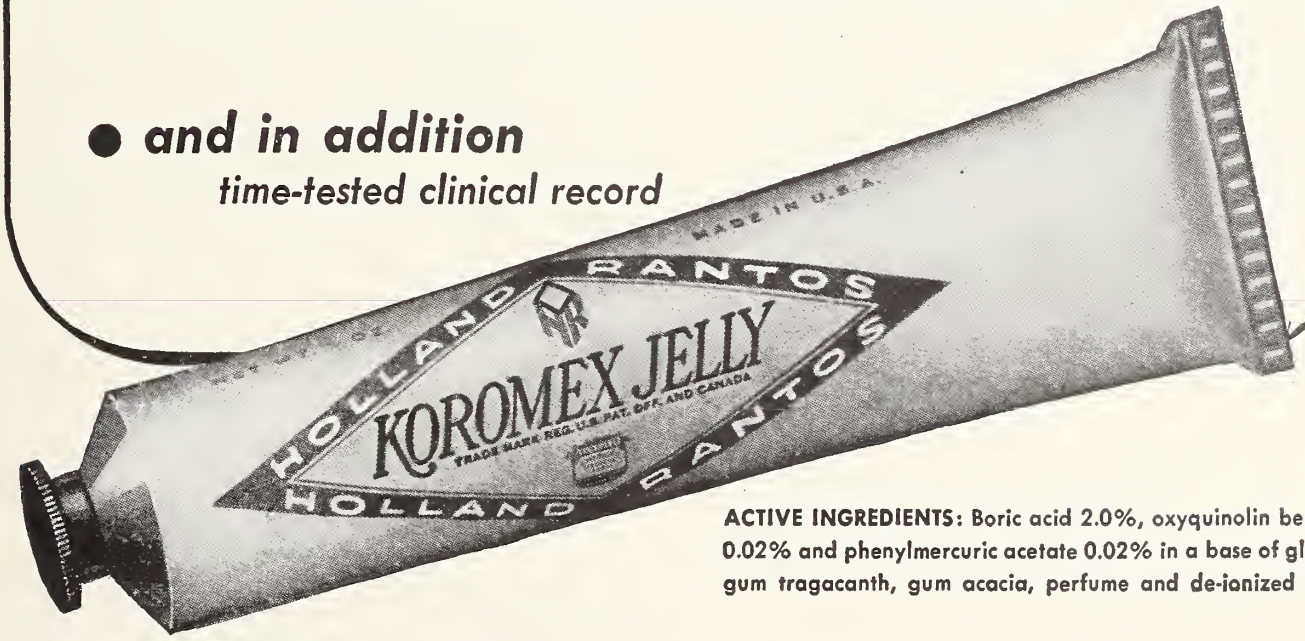
Presque Isle — Northern Maine Sanatorium, 1.30 p. m.: Mar. 26, May 21, July 23, Sept. 24, Nov. 19.

Clinic visits by appointment only. Referrals may be sent to: Division of Services for Crippled Children or Division of Maternal and Child Health, State Bureau of Health, Augusta, Maine.

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From where I sit
by Joe Marsh

How to Stop Worrying

I guess folks in our town do about as much worrying as in yours—over housing and prices, and crops, and jobs—and the little domestic problems that are always coming up.

Dad Hoskins, who's lived to the happy age of eighty, has a simple formula for stopping worry. About every problem, he asks himself: Is there anything I can do about it? If there is, he never postpones making a decision, or taking whatever direct action he's able to.

If there isn't anything he can do about it, he sets aside a "worrying hour" after dinner, and gets his worrying over in one concentrated period. When that's over, he relaxes over a friendly glass of beer with Ma Hoskins—and they talk about pleasant things together, until bedtime.

From where I sit, that's about as workable a formula as you could find anywheres . . . right down to the mellow glass of beer that seems to wink away your worries.

Joe Marsh

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Pathology of Malaria—Continued from page 59

For these patients, we repeat the tests in a week and if the results are still positive, we inform them to have repeat tests done monthly for a period of three months. In malaria, the reagin titer will have dropped appreciably by that period to negative, unless they have a relapse. Quantitative flocculation or complement fixation tests are very helpful in determining the fall in reagin titer. It is important to remember that the serological tests for syphilis are not specific reactions and that the diagnosis of syphilis should not be made from these tests alone, especially if the patient has had recent malaria.

With the return of many veterans who have contracted malaria, a hazard has arisen in the use of blood transfusions. A recent article in the *J. A. M. A.* stresses the importance of selecting blood donors. They state that, although patients acquiring malaria by inoculation respond readily to treatment and generally do not have any relapses, there is no justification for risking inoculation by failure to take suitable precautions. Donors that have been in a malarious area and have had an attack of malaria, should not be used for at least two years after leaving zone, provided they discontinued suppressive treatment then and have not had recurrences of malaria for at least two years previous to their donation. If donors were in malarious areas and have not had any attacks of malaria and for the past year have not taken any suppressive treatment, they may be used if the thick film does not show any parasites. Physicians should be watchful if a patient devlops chills and fever about a week after receiving blood from a donor who has been in an overseas malarious area.

References

1. Human Malaria Symposium, A. A. A. S., Science Press, 1941.
2. Mackie, T. T., Hunter, G. W., and Worth, C. B.: A Manual of Tropical Medicine, W. B. Saunders Company, 1945.
3. Strong, R. P.: Stitt's Diagnosis, Prevention and Treatment of Tropical Diseases, The Blakiston Company, 1943.
4. Craig, C. F.: Laboratory Diagnosis of Protozoan Diseases, Lee & Febiger, 1942.
5. Maytum, C. K., and others: Malaria, Proc. Staff Meet., Mayo Clinic, 21:269, 1946.
6. *J. A. M. A.*, 132:150, 1946.

The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, April, 1947 No. 4

*The Problem of Cancer of the Cervix**

Theodore C. Bramhall, M. D., Portland, Maine

Eight hundred and four women died of cancer in the State of Maine in 1944. This is the most recent year for which statistics are available. One hundred and fifty-six of these women died of cancer of the uterus. Of these 156, fifty-six deaths were reported due to carcinoma of the cervix and one hundred to "other and unspecified sites." Obviously, many cases of carcinoma of the cervix were reported as of the uterus. Statistics show that about 13% of cancer of the uterus is of the fundus, and 87% is carcinoma of the cervix. Corrected mortality figures for this state should show that there were approximately twenty deaths from cancer of the uterine fundus, and one hundred thirty-six deaths from carcinoma of the cervix. For the statistical year studied, the cervix is the most frequent site of fatal cancer, followed closely by cancer of the breast, with 129.

It is obvious from these figures that carcinoma of the cervix is a major cause of cancer deaths among females. Because of this, we should pause and review our methods of handling these cases, both as to diagnosis and treatment, and endeavor to improve our results. The literature abounds with descriptions of methods of treatment of this condition, yet it would seem that but little has been accomplished in the improvement of our results durthe past several years. Until some new means is found for the cure of cancer, our results in therapy will remain static. To improve our results, it is imperative that patients be diagnosed and treated at an earlier stage of the disease.

At the Tumor Clinic of the Maine General Hospital during the years 1942-1945, inclusive, there were 297 new patients (both male and female) admitted on whom a diagnosis of cancer was made. Eighty-four of these proved to be cancer of the cervix, or 28%. These patients have been classified into the following groups:

Group I: Those cases where the lesion involves the cervix alone.

Group II: Those in which the lesion is more extensive, including the adjacent vagina.

Group III: Where the lesion has further spread to include the parametrium.

Group IV: Where the disease has become generalized and with distant metastases.

* Presented at the 92nd Annual Session of the Maine Medical Association, at Poland Spring, June 25, 1946.

Of the eighty-four cases of carcinoma of the cervix, there were:

6 in Group I	Or	7%
32 in Group II	Or	38%
38 in Group III	Or	45.5%
8 in Group IV	Or	9.5%

It is obvious from this analysis that over half of the patients coming into our clinic with cancer of the cervix fall into Groups III and IV; groups where the disease has extended beyond the confines of the organ involved and for which therapy offers very little.

It is interesting to note the number of patients who survive after adequate therapy has been given. In a recently published analysis the Jefferson Clinic reports the following five-year survival rate of cancer of the cervix:

Group I	75%	Survival
Group II	43.3%	Survival
Group III	22.1%	Survival
Group IV	0%	Survival

Applying this survival rate percentage to our patients, the following results can be anticipated:

Of 6 cases in Group I—4 should be living in 5 years.

Of 32 cases in Group II—13 should be living in 5 years.

Of 38 cases in Group III—8 should be living in 5 years.

Of 8 cases in Group IV—0 should be living in 5 years.

We can anticipate that under proper therapy 25 of our original 84 patients will survive the five-year period (or 30%). Why is this survival rate so low? The answer is simple: Cervical cancer, if diagnosed early, can be successfully cured; but if the cancer is far advanced, the treatment is relatively hopeless.

Recently, new patients applying at our Tumor Clinic at the Maine General Hospital have been asked how long their symptoms have persisted prior to their seeking medical aid. Of 58 patients so questioned, the average elapsed time was 10 months; the longest being five years; the least, at once. It is the duty of the physician to educate the laity in the signs and symptoms of early cancer so that they will report for examination at an earlier date.

Women should be taught:

That childbirth injuries may lead to cancer if untreated.

That leukorrhea is not a normal condition and that it frequently is the first symptom of a carcinomatous change in the cervix.

That excessive menstrual bleeding is not a normal type of menstrual flow and should be investigated.

That post-menopausal bleeding should be considered cancer until proven otherwise.

That inter-menstrual bleeding is significant and warrants examination.

That pain in the pelvis, bladder, or rectum is not an early sign of cancer *but* a *late one.*

Public education along these lines has been undertaken, very ably, by a number of societies for the eradication of cancer. Limitations, necessarily, of time and money, have proven obstacles, but not insurmountable ones. Additional publicity, particularly in the field of radio, which reaches everyone, on a year-round program, could constitute a notable improvement here.

Among the 29 patients questioned, at the Maine General Hospital Tumor Clinic, as to the length of time elapsing between the first visit to a physician and the first visit to the clinic, the average proved to be 2½ months; the longest time being 1½ years; the shortest, at once. It is regrettable that in practically all the patients whose clinic visit was delayed, the patient reported no vaginal examination having been previously made, and that symptomatic treatments had been advised, either in the form of douching, or injection therapy. A few had been told to regard it as "the change of life." I recall one patient with a Grade III carcinoma of the cervix, who had consulted three physicians before finding one who had made a vaginal examination, and referred her to the Clinic.

It is indeed a sad commentary upon the medical profession of today that so many patients who seek advice are not afforded thorough physical examinations to establish tentative diagnoses of the disease causing these symptoms. I realize that there are many patients who will not readily submit to vaginal examinations by their family doctors, but I believe it is the doctor's duty either to examine

his patient himself, or refer her to a qualified specialist where such examinations can be made. Physicians should refuse to prescribe in the absence of coöperation—for treating a patient symptomatically is as harmful to the doctor as it is to the patient.

The Physician's part in lowering the mortality rate from cancer of the cervix can be divided into two parts:

(1) Prevention
(2) Early diagnosis

Cancer of the cervix occurs most frequently in multiparas where the cervix has been lacerated and the lips of the cervix eroded. Shortly after trauma, infection of this erosion takes place with a resulting endocervicitis and vaginal discharge. This irritating discharge may in time, in susceptible individuals, give rise to cancer. The physician can prevent this train of symptoms by insisting that all post-partum cases return for a six weeks' check-up, at which time the cervix can be inspected, lacerations and erosions seen, and adequate treatment, by means of the cautery or endotherm, given. By burning down these granulations at this time, prevention of endocervicitis and, ultimate cancer, may be achieved. It is not difficult to cauterize the post-partum cervix; no anesthesia is required. All that is needed is an inexpensive electric cautery. This procedure can be done by any general practitioner in his office. My experience has revealed that there are very few post-partum cases who do not require this simple procedure.

At the time of this check-up examination, the physician has an excellent opportunity to suggest to his patient that she return for an annual check-up examination so that any change in the character of the cervix and beginning signs of cancer may be detected.

In those cases coming to the physician because of vaginal discharge, it is the physician's duty to make a vaginal examination. This should include a bimanual and also a speculum examination under good light. All vaginal discharges are not due to endocervicitis. Some, and perhaps most, are due to trichomonas vaginalis. An accurate diagnosis should be made, and if endocervicitis is the cause of the patient's discharge, than appropriate therapy, in the form of cauterization, conization, or amputation of the cervix can be done. I have yet to see a case of deep-seated endocervicitis cured by the application of medicated tampons or douches. The cervical glands must be destroyed, and this can be done only by active destructive therapy, as mentioned previously. Here again these patients should be encouraged to return for check-up examinations at regular intervals.

The early diagnosis of cancer of the cervix requires accuracy of observation both as to touch and sight, combined with a knowledge of the pathology involved. The symptoms of early cancer may be minimal; perhaps only a mild vaginal discharge or it may be accompanied by irregular staining of blood which may become noticeable only after strenuous exercise, intercourse, douching, or vaginal manipulation. As the disease progresses, the discharge increases and is consistently blood-tinged, and usually a bad odor accompanies this discharge as ulceration and infection take place.

On digital examination, there may be a hard nodular feeling to the cervix and blood is not infrequently found on the examining finger. Visual examination in the very early cases may show only an erosion of the cervix, but on wiping with cotton there may be a small area which bleeds easily. It is from this area that a biopsy should be taken.

In the recognizable early cancer of the everting type, the lesion is frequently found on the anterior or posterior lip situated usually in the region of the external os. It may be circumscribed, elevated, or granular; it is usually indurated, sometimes lobulated; it bleeds easily on slight manipulation or rubbing with a cotton sponge.

A second type of cancer is found in the cervix and usually escapes recognition until too late. That is the so-called nodular type which starts in the endocervix and may progress laterally without breaking through the vaginal portion of the cervix where it can be easily seen. This type of cancer can be best detected by passing a small cotton-wound applicator into the endocervix. If bleeding occurs, one should become suspicious and investigate the endocervix by means of a small sharp curette. If tissue is obtained, it should be sent to the laboratory for study.

While a few early cases of everting cancer of the cervix are easily recognizable, we shall have to depend for our final diagnosis on the results of the biopsy. A biopsy should be taken of all areas of the cervix that bleed easily to touch, ulcerating and everting growths, cervical polyps, and tissue obtained by exploring the endocervix with a curette.

The taking of the biopsy is not difficult. It can be done by cutting with a knife, a biopsy punch, or the endotherm loop. It is not a hospital procedure nor is it accompanied by pain. Tissue obtained should at once be placed in 10% Formalin and sent to the laboratory for examination.

It is well at this point to introduce a word of caution on not forgetting the patient if the biopsy report should come back negative. It has been our experience at the Clinic that too frequently biopsy reports have been returned as negative but in a few months patients have returned with well marked cancer of the cervix. A patient who shows a suspicious cervix should be kept under observation until the danger of cancer can be ruled out.

There are two aids in the making of an early diagnosis of cancer of the cervix that deserve mention at this time. They are: (1) Schiller's Test and (2) Vaginal Smear Method.

The Schiller Test is based upon the theory that cancerous epithelium in its early stages contains little or no glycogen. Lugol's solution applied to the cervix stains normal tissue a deep chestnut brown. However, an area of early cancer will not take the stain or will stain only faintly. Erosions and areas of leukoplakia do not take the stain and, therefore, make the interpretation of this test confusing. It is useful only in selecting a site to take a biopsy in a suspicious early case.

Recently, a new method for early detection of cancer of the uterus has been brought to our attention by Papanicoleau — the so-called vaginal smear method. In this method, the contents of the posterior portion of the vagina, the endocervix, or the uterine cavity are aspirated; the material spread on a slide and immediately fixed in 95% alcohol and ether. The smear is then stained by a special stain. Persons experienced in the examination of such smears can detect cancer cells of the cervix or uterine fundus. A positive smear tells one that the patient has cancer and it is up to us to find it. A negative test does not rule out cancer. The difficulty in using this method of early detection of cancer lies in the fact that only a person trained in the study of vaginal cytology is competent to make the examination and, thus, all smears must be sent to a laboratory where a trained observer can make the examination. At the present time, there are few laboratories so equipped.

Our problem, therefore, in salvaging more patients who are suffering from carcinoma of the cervix is two-fold: (1) Education of the lay-person as to the importance of recognition of the early signs of cancer, and (2) The re-education of physicians in the prophylactic treatment of the cervix, and in the early recognition of cancer.

The single flaw in the remarkable progress in the control of tuberculosis in the United States is the fact that the disease is still a major cause of death, killing more Americans than all other infectious and parasitic diseases combined. In spite of a constant search for drugs to effect a lasting cure, no substance has been found that is completely satisfactory. Various sulfonamides, although capable of modifying the disease in experimental animals, have proved too toxic for continuous use in human patients, and streptomycin, which provides considerable protection, has not effected permanent cure. Since no specific remedy has been discovered, the accepted methods of treatment, which have obtained excellent results in a great many cases, must be relied on. Editorial, *N. E. Jour. of Med.*, Dec. 5, 1946.

Proficiency in tuberculosis control within a hospital is as essential to sound hospital administration as proficiency in aseptic technique in the operating room or control of typhoid fever in the medical ward. Leopold Brahdy, M. D., *Jour. Ind. Hyg. and Tox.*, Oct., 1945.

*Gastrointestinal Bleeding: Roentgenological Considerations**

Jack Spencer, M. D., Portland, Maine.

The material for this paper is based on a review of 175 cases of proven duodenal ulcers as demonstrated by Roentgen examination. In reviewing these cases special attention was given to these cases which had been admitted due to hemorrhage and there were fifteen such cases.

An analysis of this group revealed considerable variation in time from the day of admission to the day the Radiological studies were made. It is often a problem as to when to Radiograph a case which has been bleeding. In our group the time interval was between three days and thirty days. In the case X-Rayed thirty days after the hemorrhage, the findings were inconclusive although suggestive of a duodenal ulcer. This is a frequent finding in the cases of bleeding ulcers of the stomach and duodenum, as it has been demonstrated the Roentgenological findings of an ulcer can disappear within one week.

Duodenal Ulcer Roentgenological Findings in 175 Hospitalized Cases

1. Active—70.
 Active with hemorrhage—15.
2. Posterior wall—3.
3. Scar tissue—50.
 With obstruction—15.
4. Presumptive evidence—12.
5. Perforated Duodenal Ulcer—3.
6. Anterior Wall—1.
7. Duodenal ulcer and Gastric ulcer—6.

An analysis of findings in this group of cases from the stand-point of the demonstration of the lesions was of interest. The ulcers which showed a crater surrounded by edema were classified as active. There were 70 cases and 15 cases were admitted with hemorrhage. There were three cases in which the ulcer was demonstrated on the posterior wall. An ulcer located in this position is more likely to hemorrhage and also a small ulcer in this area is more difficult to demonstrate as often there is no definite deformity of the duodenal cap to indicate the presence of an ulcer. Cases with a clover-leaf deformity suggesting a lesion either definitely active or with scar tissue only and producing obstruction totaled sixty-five. There were twelve cases in which the ulcer itself was not demonstrated. The study does not give an accurate number of perforated ulcers as some of the cases were not radiographed before discharge. Combined gastric and duodenal ulcers totaled six and in this group one was admitted with bleeding.

Age Incidence

The age incidence in this group of cases is of interest in that the youngest case was four years of age and there were three cases under the age of twenty. One of these cases. age sixteen, was admitted with bleeding due to a duodenal ulcer. Nine were between twenty and thirty and forty cases were over sixty years of age. There were one hundred-twenty cases between thirty and sixty years of age.

In addition to this group of duodenal ulcers, representative cases have been selected to illustrate some of the causes of gastro-intestinal hemorrhage with the discussion limited to the stomach and duodenum.

Case 1.

White male, age twenty-five, admitted to the hospital with history of vomiting blood. Treated for one week with recurrent hemorrhage. Roentgen examination after one week revealed a large lesser curvature gastric ulcer which appeared to be benign. The surgical specimen revealed a ruptured blood vessel extending to the base of the ulcer crater.

* Presented at the 92nd Annual Session of the Maine Medical Association, at Poland Spring, June 24, 1946.



FIGURE 1, CASE 1

Roentgenogram shows large lesser curvature gastric ulcer.



FIGURE 3, CASE 3

Film taken in supine position with the right side up demonstrates a large ulcer crater which was proven to be a slowly growing adeno carcinoma.



FIGURE 2, CASE 3

Roentgenogram shows a deformity of the antrum. Additional view taken under fluoroscopic control demonstrates the ulcer crater.



FIGURE 4, CASE 4

Roentgenogram demonstrates lesser curvature ulcer which on resection showed an adeno carcinoma arising from a peptic ulcer.

Case 2.

E. B., age thirty-six admitted to the hospital with a history of epigastric pain of one month's duration which was relieved by eating. Laboratory studies revealed occult blood in the gastric secretions. Roentgen studies revealed a lesser curvature gastric ulcer and a duodenal ulcer. Patient had a gastric resection and a healing gastric ulcer was demonstrated.

Case 3.

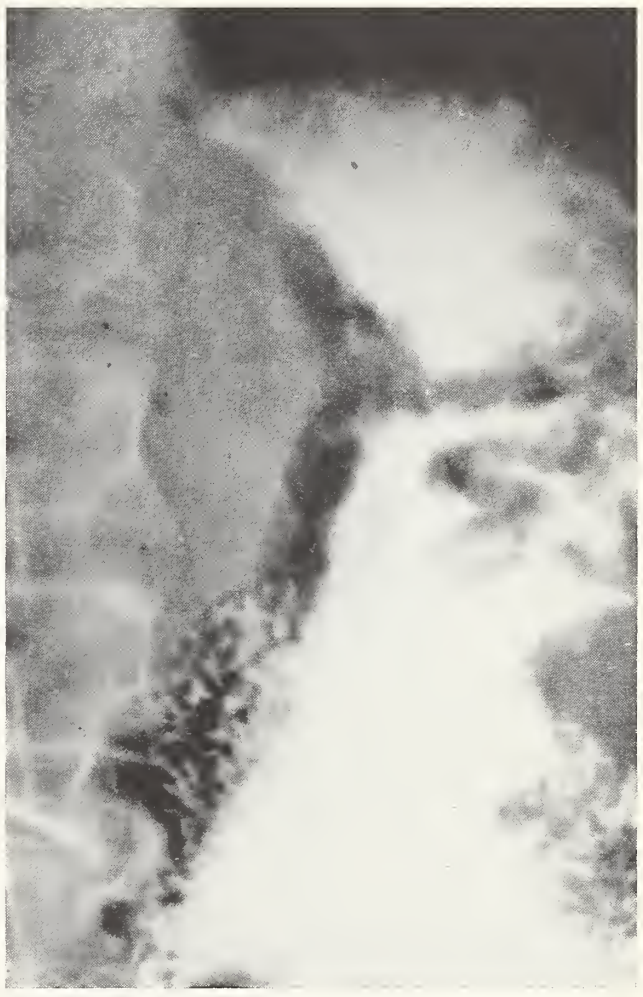
J. T., age 38, admitted to the hospital with history of epigastric pain intermittent for four years with recent nausea and vomiting. The Roentgen studies revealed at first a deformed antrum and duodenum. Re-examination revealed a lesser curvature gastric ulcer with considerable spasm. The ulcer crater increased in size. Laboratory studies revealed occult blood in the gastric secretions. The stomach was resected and the pathological report was that of a slowly growing adeno carcinoma with four negative lymph nodes.

Case 4.

H. T., age 59, admitted to the hospital with history of acute pain after eating which was relieved by milk. Roentgenological studies revealed a lesser curvature gastric ulcer which decreased in size within two months with recurrence of symptoms with the ulcer increasing in size indicating the lesion was probably malignant. Gastric resection done and Pathological report was that of an adeno carcinoma arising from a peptic ulcer.

Case 5.

J. C., age fifty-two, admitted to the hospital. The clinical diagnosis was that of pneumonia and during convalescence from pneumonia, the patient vomited blood. Laboratory studies revealed eighty percent hemoglobin, 3, 800,000 red blood cells and 15, 200 white blood cells. Roentgenological studies revealed definite changes in the gastric rugae in the greater curvature of the middle third of the stomach. The changes were constant over a period of a month. A diagnosis of hypertrophic gastritis was made. Follow-up examination over a period of one year demonstrated no change.





FIGURES 5 AND 6, CASE 5

Roentgenograms demonstrate marked changes in the gastric rugae which persisted over a period of one year and was diagnosed as hypertrophic gastritis.



FIGURE 8, CASE 6
Photograph of specimen. Reported a malignant tumor probably of neurogenic origin.



FIGURE 7, CASE 6
Roentgenogram shows large tumor mass in the lower portion of the stomach.



FIGURE 9, CASE 7
Roentgenograms show a benign gastric ulcer and duodenal ulcer.

Continued on page 96

*Progress of Medicine Series**

Penicillin Therapy in Syphilis

Leon Babalian, M. D., Portland, Maine

During the last few years American scientists have done intensive research on the prevention as well as the treatment of Syphilis. Concerning prevention, methods based on those in Denmark were applied so systematically that they are bound to produce results. In regard to treatment, schedules of intensive and semi-intensive arsenical treatments were studied to an extent unknown in other countries. And, last and most important of all, the beneficial effect of Penicillin in Syphilis was discovered. One day, in 1943,[9] John Mahoney stood before a packed audience assembled for the annual meeting of the American Public Health Association and announced the first successful treatment of four early cases of Syphilis. It was a "dramatic episode."[20] Since then, important results have been obtained in a short while, thanks to the collaboration of large groups of scientists: The Committee on Medical Research of the Office of Scientific Research, with the support of an office of statistics, centralized the research work of seven laboratories of experimental Syphilis and forty-one clinics. As early as 1945, they had records of 11,000 cases of Penicillin treatment in early Syphilis. The magnitude of this effort was made possible by the financing and supervision of the U. S. Public Health Service. It is impossible to mention the names of all those who participated in this group. Among them were Eagle, Mahoney, Stocks, Moore, O'Leary, Udo Wille. We should guard, however, against over-optimism and not repeat the error of 1910. At that time, the discovery of 606 led everyone to believe that the end of Syphilis was imminent. We can measure today the extent of this error. It takes several years to judge the efficacy of a new antiluetic drug.

Before going further into the subject, it would be well to recall a few generalities concerning Penicillin:

a) Since May, 1944, results obtained with Penicillin have been less satisfactory than those obtained before that time. It was believed that a new strain of Treponema pallidum, resistant to Penicillin, had developed. The truth was different. In fact, commercial Penicillin is not a single substance, but a mixture of at least four types, called G, X, F and K. The relative proportion of these different types varies from one year to another. Originally, commercial Penicillin was predominantly Penicillin G, unpurified, containing 200 units only per mg. and very potent. A nationwide inquiry showed that since 1944 it has been a purified, crystaline product containing 1,000 or more units per mg. and predominantly of the type K. It was proved experimentally that this type was less active and provided much lower and much less well-sustained blood levels than other types. Consequently, for the treatment to be absolutely efficacious we must go back to the type used before 1944. Until the present stocks are used up, it is advisable to use larger doses.[3]

b) Penicillin should be given by intramuscular injection. Intravenous injections have been used; they exposed the patient to phlebothrombosis, diarrhea, hematuria and albuminuria. "Under no circumstances should Penicillin in its present available form be administered orally for the treatment of Syphilis."[3]

c) The use of Penicillin has been seriously hampered by its rapid excretion and by the consequent necessity of frequent administrations in order to maintain an adequate blood level. Experiments have been performed in which a slow release of Penicillin could be obtained in the body by the parenteral administration of Penicillin in sesame oil (Gladys Hotby), by the administration of esthyl esters (Karl Meyer), or by methyl esters of Penicillin (Levaditi and Vaisman).[8] At present, the only satisfactory method of absorption-delaying of Penicillin is the administration of Cal-

* Inaugurated by the Committee on Graduate Education.

cium Penicillin in peanut-oil beeswax, known as the method of Romansky. We will discuss this later.[17]

d) Penicillin is already magnificently efficient when given alone. When combined with an arsenical treatment, its action is enhanced, as demonstrated experimentally; but, for reasons given further along, the use of this combined treatment should be avoided.

e) Penicillin action is delayed. This fact should be known in order not to underestimate the efficacy of the treatment. Except for the disappearance of Treponema from early lesions in 24 hours, other improvements are delayed. Several months are necessary to judge its complete efficacy in, for instance, neurosyphilis, and it is difficult in this case to determine what proportion of the improvement is due to Penicillin and what proportion to another factor.

In the same way, the serologic improvement is slow. To judge it accurately, we must have recourse to quantitative tests. It takes from 2 to 7 months for a positive blood test to revert to negative. A curious fact is that changes occur more rapidly in spinal fluid (when it is affected) than in the blood.

f) Like arsenic,[10] Penicillin has two opposite effects. In the first few hours it can be activating, *"biotropic,"* aggravating temporarily the lesions. This reaction, known as Herxheimer Reaction, should never be a cause of cessation of treatment. On the contrary, it demands continuation of treatment, the *antibiotic* effect of which will soon appear.

g) This Herxheimer Reaction should be distinguished from allergic reactions due to Penicillin. These sensitizing reactions are rare with Sodium Penicillin, especially the purified one. They are more frequent with Calcium Penicillin in peanut-oil beeswax.

h) Another inconvenience of Penicillin therapy may appear when it is given in Gonorrhea. The dose of Penicillin may mask an incipient Syphilis and allow the patient to be exposed to the dangers of an unrecognized Syphilis. Consequently, every case of Gonorrhea treated with Penicillin should have repeated clinical and serological examinations.

Penicillin therapy was studied essentially in: a) early Syphilis; b) prenatal Syphilis; c) early congenital Syphilis; d neurosyphilis. The study of other syphilitic manifestations was considered less urgent and has not been extensively carried out up to now.

Early Syphilis (Primary and Secondary)

Treatment of early Syphilis by Penicillin is of the utmost interest because of the rapidity of its action and its safety. Twenty-four hours after the beginning of this harmless treatment, Treponema cannot be found any longer in cutaneous and mucous lesions. At the beginning of this treatment, the lesions may look worse. A chancre and its regional nodes may increase in size. A roseola and its moderate fever may be aggravated. All these are manifestations of the above-mentioned Herxheimer Reaction. This reaction is present in 59 per cent of cases of early Syphilis treated with Penicillin; as previously stated, the presence of this reaction does not mean that Penicillin has a toxic effect, but that Penicillin should be continued energetically.

More than 11,000 cases of early Syphilis were treated with Penicillin and their reports studied by the Committee on Medical Research.[2] Twenty-six different treatment schedules were tried. In each, Penicillin was administered in the form of Sodium Penicillin in aqueous solution, and only intramuscularly. The differences concerned the amount of each injection, the interval between injections, and the total duration of treatment (consequently, the total amount). Finally, different schedules were elaborated when Penicillin was given alone or associated with arsenoxide or bismuth, or both. The reports of this study make complicated reading, so packed are they with statistics and graphics. The following dominating facts stand out:

a) Penicillin Alone

1) Penicillin is the more active, the sooner it is started.

2) The blood test, when positive, reverts to negative in from 2 to 7 months.

3) The most effective schedules are those when the total dosage is divided into 60 injections with one injection every 3 hours around the clock; i.e., 7½ days' duration.

4) The most efficacious dosages are those of 1.2 million units and 2.4 million units. These dosages give at the end of the seven months 59 per cent negative blood tests with the first dose, and 49 per cent with the second.

We might conclude that the 1.2 million dose is preferable to the 2.4 million dose. This conclusion will be erroneous because of two other factors: a) The relapses. The failure rate varies in reverse ratio to the administered dose. Clinical relapses are exceptional. More often, it is a question of serologic relapses, although it is rare that the rate of positivity reaches the same serologic titer as before treatment. b) Loss of activity of present commercial Penicillin. Because of these two factors, the preferred total dosage is 2.4 million units (i.e., 40,000 units every 3 hours until 60 injections are given). This dose gives the lowest failure rate — 15 per cent. This rate, we confess, is high, even if we admit, as we do, that several of these so-called failures are not in reality failures, but true reinfections. Anyway, the rate remains higher than the one observed during the years following the arsenoxide-bismuth treatment. Consequently, Penicillin alone is not superior to arsenoxide-bismuth in early Syphilis; but, it is preferable, due to the following facts: a) its rapidity of administration; b) its non-toxicity; c) the low rate (2 per cent) of positive spinal fluid after treatment,—a rate "which is a decidedly lower percentage than that observed after arseno-bismuth therapy."[13]

b) Penicillin Combined

In spite of this advantage, Penicillin alone does not appear effective enough in early Syphilis to use without fortification. Penicillin combined with arsenoxide bismuth is recommended, more especially as Penicillin action is enhanced by this association, as demonstrated experimentally. This association can be made in three ways: 1) Penicillin therapy preceded by semi-intensive arsenoxide treatment and followed by bismuth.[13] 2) Penicillin given concurrently with arsenoxide and bismuth: during the 7½ days of treatment the patient is given also five intravenous injections of arsenoxide at the dose of 40 mg. each, and three injections of bismuth.[2]

These two methods give, beyond a doubt, excellent results; but they should not be used as they are dangerous. Their use can only be justified in young patients, in perfect health, who are carriers of surprisingly relapsing Syphilis.

3) Penicillin followed by a slow arseno-bismuth treatment,—such as a minimum of 10 weeks of arseno-bismuth treatment; some advise 40 weeks. "If one could compare the danger of inadequately treated Syphilis to the slight inconvenience of a prolonged treatment, beyond what is strictly necessary, one does not hesitate to choose the alternative which has more assurance of curing the patient."[1]

c) Penicillin in Peanut-Oil Beeswax (P. O. B.)

In order to obviate the need for hospitalization, Romansky[17] et al proposed to treat cases of early Syphilis with one single injection of 300,000 units for 8 successive days, the total dosage remaining the requisite 2.4 million units. In order to delay the absorption of these small daily doses and to maintain satisfactory levels in the blood for 24 hours, Calcium Penicillin is injected in a mixture of peanut-oil beeswax (P. O. B.).

In the same way, Evan Thomas et al[23] treated early Syphilis with daily injections of 600,000 units of P. O. B. for 8 successive days (i.e., a total dosage of 4,800,000 units). The results obtained from 802 cases are very encouraging. These are, however, too recent to formulate any decisive conclusions, especially concerning Serology, which is always slow to be modified in "rapid treatments" — whatever the treatment may be.

There is no doubt but that this Penicillin therapy by P. O. B. is of the utmost interest. Its great advantage, as mentioned before, is that hospitalization is not necessary. This method, however, has certain disadvantages. One is the high incidence of local reaction, especially if the injection is not strictly intramuscular. More serious are allergic reactions manifested by the development of urticaria in from 5 to 6 days following treatment.

Although these manifestations are easy to relieve with Benadryl, — although, too, this mix-

ture seems to be well tolerated by the muscle and never provokes appearance of paraffinomas, this method is still in the experimental stage and its use is not advisable yet for the practitioner in the treatment of Syphilis.

Prenatal Syphilis[4, 7]

Penicillin therapy in syphilitic pregnant women has been given on a large scale at the clinics of Johns Hopkins and Pennsylvania Universities. In general, the results were the same. They demonstrated the outstanding value of Penicillin in prenatal Syphilis. They demonstrated also the harmlessness of Penicillin to the mother and the fetus. In 101 cases of pregnant women at every stage of Syphilis (early and late cases compiled), there were four abortions and seven threatened abortions. In all probability, Penicillin was not the cause, because in normal non-syphilitic and non-Penicillin treated women, about 10 per cent of pregnancies end in abortion. Penicillin should be given *alone* at the total dosage of not less than 2.4 million units in 7½ days. This treatment should be repeated in the last months of pregnancy if the blood test has not reverted to negative, or if an increase of the rate of reagin announces a serologic relapse. The results of Penicillin therapy alone are the following:

1) *Mothers with early Syphilis:* Whatever may be the stage at which the treatment is given, either before or after the fifth month of pregnancy, results are excellent. Out of 60 births, 59 were and remained free of Syphilis, clinically and serologically. There was one case only of congenital Syphilis, a failure rate of 1.6 per cent,—an accident which probably would have been avoided if a serologic relapse of the mother had been detected in time. This result is far and away superior to that obtained with arsenoxide-bismuth therapy, which has a failure rate of: a) 5 per cent when treatment is started before the fifth month; b) 50 per cent, when treatment is given at the end of pregnancy.

2) *Mothers with late Syphilis:* Results remain good "though hardly as impressive as in early maternal Syphilis."

Therefore, Penicillin therapy is incomparably superior to arsenoxide-bismuth therapy in the prevention of prenatal Syphilis. In view of the danger of arsenic and bismuth therapy, and the lack of danger of Penicillin in pregnant women, "We are prepared to recommend that, for the purpose of prevention of prenatal Syphilis, metal-chemo therapy for the syphilitic mother, whether with early or late (including Latent) Syphilis, be abandoned and that Penicillin be adopted universally in its stead."[4]

The condition of the infant will be determined by: a) clinical signs; b) roentgenograms of the long bones taken preferably at the first and sixth weeks of life; c) last, but not least, by quantitatively titered blood tests, which should be repeated during the first three months. It is understood that positive blood test at birth does not necessarily signify that the baby is syphilitic. Reagins of maternal origin could pass to the child and give temporary positivity.

The treatment of Penicillin alone during pregnancy does not preclude additional treatment for the mother after delivery. It may be necessary then, but at that time only, to use combined arsenoxide-bismuth therapy.

Early Congenital Syphilis

At birth, syphilitic infection is already old. Therefore, Penicillin is less effective in the treatment of congenital Syphilis than it is in its prevention. However, it remains the best drug for the treatment of this condition. From the comprehensive study of the cases reported on by the clinics of Tulane, Pennsylvania, Johns Hopkins, and Texas Universities, the following facts stand out:

a) Treatment is the more efficacious the sooner it is begun, although the interpretation of statistics is confusing. We should, indeed, take into account the fact that congenital Syphilis has a tendency to improve spontaneously. The cases still in great activity after 6 months of life are, of course, more resistant, and, naturally, the rate of cure among them will be low.

b) The total dosage should be larger in proportion to weight than that given to adults. For a total dosage of 2.4 million units, the adult is given about 32,000 units per kilogram. This dosage should be increased considerably for the infant. Platou recommends a total dosage of not less than 100,000 units of the present commercial Penicillin per kilogram of body weight.[15]

c) As important as the high dosage is the prolonged action at low concentration. The total dosage should be divided into 120 injections,—one injection every 3 hours (total duration, 15 days). So many injections given to a newborn baby might cause difficulties.[6]

d) Generally speaking, this treatment gives "satisfactory" results in 74 per cent of cases.[15]

e) It is possible to see serologic relapses, especially from 6 to 11 months after treatment, but their rate is greatly compensated for by improvements which continue to appear.

The general conclusion is that the efficacy, rapidity of action, and safety of Sodium Penicillin alone in this stubbornly chronic disease have amply demonstrated that "this drug is the best single agent yet employed for the treatment of congenital Syphilis."[15]

This drug should, however, be administered with care, especially in greatly debilitated babies. Forty per cent of the infants treated with Penicillin develop symptoms of severe gastro-intestinal disturbances with fever. These troubles are common in untreated syphilitic infants, and it is not impossible that the exacerbation of these troubles during Penicillin treatment is nothing more than Herxheimer Reaction. In any case, great precautions should be taken.[6]

Neurosyphilis

Penicillin injected intramuscularly goes into the spinal fluid. This experimental fact justifies the hope in the efficiency of Penicillin treatment in Neurosyphilis. It is too early to make conclusive deductions as to the merit of this treatment. From comprehensive studies made at Pennsylvania and Johns Hopkins Universities, from the Mayo Clinic, and the Boston Psychopathic Hospital, the following facts have been ascertained: The action of Penicillin is certain on spinal fluid.[16] The return to normal limits of the lymphocytic count is observed in two months after treatment almost invariably. The same change occurs, but later, for total protein. The colloidal curve is favorably influenced, but neither so promptly nor completely as in the case of the cells' count and total protein. As for the Wassermann—it tends to remain persistently positive, but its titer is lowered gradually. Besides, there is no concomitance recognizable between blood and spinal fluid improvement, and the blood fails to show improvement in 46 per cent of cases with definite spinal fluid improvement.[20]

Spinal fluid changes are not necessarily accompanied by a corresponding degree of clinical improvement. The latter, when it appears, takes longer than the improvement in spinal fluid. The rate of cases which have become normal clinically 13 months after treatment is 62 per cent.[20] When Neuorsyphilis is an asymptomatic one, this rate is higher and is practically 100 per cent. In symptomatic Neurosyphilis, the meningo-vascular forms respond better to treatment of Penicillin alone than parenchymatous forms. In tabes, "leg pains" are improved in 15 per cent of the cases, while ataxia, gastric or rectal crises, incontinence, and dysarthria are not helped when Penicillin is given alone. It should be associated with fever therapy. In Dementia Paralytica, there is an improvement of the mental status in 46 per cent of cases treated with Penicillin alone, and 58 per cent when Penicillin is combined with fever therapy. Optic atrophy is unimproved with Penicillin alone, while Penicillin-fever therapy offers more encouragement in arresting the progressive loss of vision than any system of treatment previously used for this condition.[12]

Penicillin is given at the dose of 4.8 million units divided into 60 doses of 80,000 units each every 3 hours. As for fever-therapy, preference is given to malarial therapy in such a way as to obtain from 4 to 6 paroxysms of fever concurrently with Penicillin therapy.[18] The use of malarial infection is possible since Penicillin does not affect this infection. For the same reason, we could probably have recourse to typhoid vaccine, which is unaffected by Penicillin and more easily handled in small centers.

Other Late Syphilitic Manifestations

Penicillin was tried, but on a smaller scale, in other late syphilitic manifestations.[13]

a) It is an outstanding remedy for the treatment of late cutaneous and osseous Syphilis, where it exerts a beneficial effect on both the syphilitic process and the secondary invading organisms.

b) Results from Penicillin therapy in the visceral forms of the disease are likewise good.

c) Cardio-vascular diseases of syphilitic origin, as well as latent Syphilis with fast positive blood test, are unaffected by Penicillin.

d) In late congenital Syphilis, cutaneous and osseous manifestations respond rapidly to Penicillin; but interstitial Keratitis, Clutton's joints (hydro-arthrosis), juvenile paresis, and eighth nerve deafness are not improved with Penicillin.[22]

Conclusion

I. Penicillin treatment of Syphilis is still in the experimental stage. Its advantages lie in the rapidity of its action in contagious manifestations (24 hours), its short duration (7½ days), and its safety. One of its disadvantages is the necessity of hospitalization.

In early Syphilis, relapses with treatment by Penicillin alone seem to be more frequent than with Arsenoxide-Bismuth therapy.

In prenatal Syphilis, Penicillin alone is beyond doubt the best treatment and should be henceforth given to the exclusion of any other drug.

In early congenital Syphilis, it is the best agent, but should be administered with care.

In Neurosyphilis, Penicillin alone is sufficient in asymptomatic form. In Symptomatic Neurosyphilis, it should be associated with fever therapy.

Penicillin has not supplanted Arsenoxide and Bismuth. It complements them admirably. It would be too simple to treat every case with Penicillin only; but to systematically ignore Penicillin therapy in Syphilis is to show a dangerous conservatism.

II. In reading about recent research work on Penicillin therapy in Syphilis, a lesson can be learned. In the short space of a few months, considerable results were obtained by the cooperation of a large group of scientists under the control of the U. S. Public Health Department with methods resembling those used in the study of atomic energy. The magnitude of this effort proves the determined will of this country to win the war against Syphilis,—a war in which up to now we have not been victorious. We know all about Syphilis; we know its germ, its mode of transmission. We have accurate laboratory methods to detect the disease in its early stage. We have efficient drugs. In spite of all our knowledge, Syphilis persists in spreading in all countries of the world. This fact is enough to discredit the medical profession everywhere. We cannot fight a war in the mediaeval way, when every lord fought on his own estate with his own methods. In this war against Treponema, we will be victorious only if we accept the methods used in any successful war: unity of command, and intensity of effort. A new weapon has been given us—Penicillin. It is up to us to make the most of it. Today, more than ever, the slogan is true: SYPHILIS CAN DISAPPEAR; SYPHILIS SHOULD DISAPPEAR.

Bibliography

1. Archambault, J.: Penicilline dans le traitement de la Syphilis. *Union Med. Canada,* 75:1655-1650, Dec., 1946.
2. Committee on Med. Research and the U. S. Public Health Service. Penicillin in early Syphilis. *J. A. M. A.,* 131:265-271, May 25, 1946.
3. Committee on Med. Research: Commercial Penicillin. *J. A. M. A.,* 131:271-275, May 25, 1946.
4. Goodwin, M., and Moore, J. E.: Prenatal Syphilis. *J. A. M. A.,* 130:688-694, March 16, 1946.
5. Heller, J.: Results of Rapid Treatment of Early Syphilis. *Jour. Ven. Dis. Inform.,* 27:217-225, Sept., 1946.
6. Ingraham, N., et al.: Syphilitic Infant. *J. A. M. A.,* 130:694-696, March, 1946.
7. Ingraham, N., et al.: Penicillin in Syphilitic Pregnant Woman. *J. A. M. A.,* 130:683-688, March 16, 1946.
8. Levaditi, C., and Vaisman, A.: Traitement de la Syphilis par Association de Bismuth et d'ester Methylique de Penicilline. *Presse Medicale,* 57: 781-782, Nov. 23, 1946.
9. Mahoney, J. F., et al.: Penicillin in Treatment of Early Syphilis. *Ven. Dis. Inf.,* 24:355-357, Dec., 1943.
10. Milian, G.: Le Biotropisme Bailliere, Paris, 1929.
11. Nelson, R., and Duncan, L.: Penicillin in Treatment of Early Syphilis resistant to Arsenic and Bismuth. *Year Book of Derm. and Syph.,* 347, 1945.
12. O'Leary, P., et al.: Penicillin in Neurosyphilis. *J. A. M. A.,* 130:698-700, March 16, 1946.
13. O'Leary, P., and Kierland, R.: Today's Treatment of Syphilis. *J. A. M. A.,* 132:430-434, Oct. 26, 1946.
14. Platou, et al.: Penicillin Treatment of Infantile Congenital Syphilis. *J. A. M. A.,* 127-582, March 10, 1945.
15. Platou, et al.: Penicillin and Congenital Syphilis. *J. A. M. A.,* 133:10-16, Jan. 4, 1947.
16. Reynolds, F., et al.: Penicillin in Neurosyphilis. *J. A. M. A.,* 131:1255-1260, Aug. 17, 1946.
17. Romansky, M., and Rein, C.: Treatment of Early Syphilis. *J. A. M. A.,* 132:847-852, Dec. 7, 1946.
18. Rose, A., and Solomon, H.: Penicillin and Neurosyphilis. *J. A. M. A.,* 133:5-10, Jan. 4, 1947.
19. Sternberg, T., and Leifer, W.: Penicillin in Early Syphilis. *J. A. M. A.,* 133:1-5, Jan. 4, 1947.
20. Stockes, J., and Steiger, H.: Penicillin in Neurosyphilis. *J. A. M. A.,* 131:1-7, May 4, 1946.
21. Vonderlehr, R., and Heller, J.: Control of Venereal Disease. Reynal & Hitchcock, N. Y.
22. Yampolsky, J., and Heyman, A.: Penicillin in Syphilis in Children. *J. A. M. A.,* 132:368-371, Oct. 19, 1946.
23. Thomas, E., et al.: Rapid Treatment of Early Syphilis with Penicillin in Beeswax and Oil. *Jour. Ven. Dis. Inform.,* 28:19-24, Feb., 1947.

The President's Page

It is becoming increasingly evident that there is considerable dissatisfaction with the charge of $35.00 for dues to the Maine Medical Association.

The dues were increased last year for the express purpose of hiring a full time executive secretary. There was nothing secretive about the matter. The proposition of hiring a full time executive secretary, which would mean an increase in the annual dues, was placed before the county societies during the year preceding the annual meeting.

The voting was very carefully held off until the last meeting of the house of delegates in order to allow sufficient time to get a general reaction to the proposition. Furthermore, after a struggle with the house, a Reference Committee was appointed to receive discussion from the delegates and the society at large. Comments received by the committee were favorable and were so reported.

In addition to this, a roll-call vote was made of the delegates present and the vote was unanimously in favor of increasing the dues to $35.00 in order to hire a full time executive secretary. Therefore, it seems puzzling to me that many men who are well informed in most things should be ignorant about this.

We have been pleading all year that the various county associations should be made stronger in every way. We have also pointed out that several meetings yearly should be given over to the discussion of the affairs that are coming up before the council meetings of the Maine Medical Association. We believe that each district should require its representative to be present at said county meetings so that his representation at the council meetings will be an accurate indication of the policies desired by his district.

We believe that if this idea were carried out, and if the individual members themselves attended their various county meetings, at least there would be no reason for any misunderstandings on any of the doings of the Maine Medical Association.

John O. Piper, M. D.,
President, Maine Medical Association.

Editorials

Heart Disease Still Leads as Cause of Death Among Doctors

Death claimed approximately 3,558 physicians during 1946 as compared with 4,015 the previous year according to the January 11 issue of *The Journal of the American Medical Association.*

On the basis of an analysis of 3,358 obituaries published in *The Journal* during the year, it was found that the average age at death was 66.1 as compared with 65.3 in 1945. The majority of the physicians—584—died between the ages of 70 and 74, the same age group that was dominant in 1945.

Heart disease remains the leading cause of death among physicians. Coronary thrombosis and occlusion accounted for 738 deaths (655 in 1945), 283 occurring between the ages 60 and 69. Cerebral hemorrhage, thrombosis and embolism accounted for 404 deaths; cancer and tumors were responsible for 352 deaths and pneumonia for 199. Tuberculosis caused 31 deaths, asthma 10, bronchitis and pleurisy five, and other diseases of the respiratory system 31.

The 3,358 *Journal* obituaries included 40 physicians who were killed in action during World War II and 128 who died in military service. A number of those who were killed in action had first been reported missing in action. Eight physicians lost their lives in the Asiatic area, seven in the Philippine Islands, six in the China Sea, five in Germany, five in the Pacific area, two in Italy, two in France, and one each in Formosa, Luzon, North African area, Okinawa and Tinian. Nine were reported as prisoners of war.

Of the 128 physicians who died while in military service, coronary thrombosis caused 19 of the 29 deaths attributed to various forms of heart disease. Airplane accidents caused 16 deaths and automobile accidents nine. Cancer was responsible for 10 deaths, three of which were brain tumors. The remaining deaths were from miscellaneous causes.

Since the outbreak of World War II on December 7, 1941, *The Journal* has recorded the deaths of 257 physicians who were killed in action and 501 who died while in military service. Reports still being received by *The Journal* indicate that the aggregate total of 758 military deaths among physicians will be greatly augmented when the complete statistics are made available through official military channels.

History of A. M. A. Will Be Distributed at Centennial

Story of American Medicine, Its Leaders, Organizations and Publications Told in Four-Part Book

An editorial appearing in the March 29 issue of *The Journal of the American Medical Association* states that a volume in four parts, containing a complete history of the association, will be available for distribution at the centennial to be held in Atlantic City, June 9 to 13.

The editorial follows in full:

"The instalment of the 'History of the American Medical Association' which appears in this issue of *The Journal* covers the years 1920-1924. With this instalment publication of the history will be discontinued in *The Journal.* The complete history of the Association up to June, 1947, will appear in the volume which is to be published by the W. B. Saunders Company for the American Medical Association. There will be additional chapters on 'The Home of the American Medical Association,' 'Dr. George H. Simmons,' 'The Libel Suits of the American Medical Association' and 'The In-

dictment and Trial of the American Medical Association by the U. S. Government.' The second part of the book will include biographies of the one hundred presidents of the American Medical Association with a picture of each and with facsimile signatures of all but one. These have been prepared by Dr. Walter L. Bierring. The third part of the book will be devoted to the Councils and Bureaus of the American Medical Association, except for some of the Councils whose work is fully described in the general account of the Association's work. The articles on the work of the Councils and Bureaus have been prepared in most instances by the secretaries of these agencies, with the exception of the article on the Judicial Council, which is written by Dr. Morris Fishbein. The history of the Advertising Department has been prepared by Mr. Thomas R. Gardiner, business manager. The fourth part of the book concerns the publications of the American Medical Association other than *The Journal* and includes articles descriptive of the history of each of them. In most instances these articles were prepared by the present chief editor of the periodical concerned. An appendix will provide tabular data, including places of meeting, the membership of many of the Councils and similar subjects. The book will be completed with both a name and a subject index. The publishers anticipate that the book will be available for distribution at the Centenary in Atlantic City in June."

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Clinical Pathological Exercise

Edited by Joseph E. Porter, M. D.

Case Presented at St. Mary's General Hospital, Lewiston, Maine

Presentation by: Dr. Frank Methot

Patient is a housewife, age 50, admitted to the hospital complaining of diffuse abdominal pain and vomiting.

Family History: Father died of pneumonia; mother of cerebral hemorrhage. Seven sisters and four brothers dead, two of cancer. One sister living. Husband and four children living and well. No miscarriages.

Past History: Does not remember childhood diseases. No history of previous illness or gastro-intestinal disturbances. Catamenia at 15, menopause at 41.

Present Illness: Ate pork three days before admission. One day before admission began to vomit green, sour, slimy vomitus. On afternoon before admission she had chills and fever, with dull pain over the epigastrium, transmitted to lower back region. Continued to vomit all night previous to admission; even water intake would provoke vomiting. No bowel movements for past four days.

Physical Examination: Toxic, restless, middle-aged woman complaining of pain in abdomen and cramps in the left side. Skin warm and moist. Teeth in fair condition. Nose, ears, throat negative. Heart: no murmurs, rate regular, 110. Chest symmetrical, expansion equal. Abdomen markedly distended and tender over its whole area but particularly in the upper portion; no splinting; no fluid wave; no masses. Viscera not palpable. Reflexes normal.

Laboratory Examination: Urine: Sp. Gravity 1.025; albumin—slight trace; sugar—negative; coarsely granular casts; rare blood discs, few leukocytes. Blood: N. P. N. 43-60 mg. on 3 exams. Sugar 138 to 148 mg.% on 3 exams. Counts on two determinations: Hb. 70 to 80%, RBC. 5.2 million; leukocytes 9,800 to 22,000; neutrophils 86 to 98%. Kahn and Hinton negative.

Clinical Progress: Temperature 98° to 99° on day of admission, until the 4th day, when it rose to 100° and to 102° on the 6th day just previous to death. Pulse ranged from 110 to 140 and respirations from 20 to 30.

She was operated on the afternoon of admission and serosanguinous fluid escaped when abdominal cavity was opened. Immediately after operation she received normal saline. Her condition was poor. She continued to vomit on the day after operation and the day following that. The abdomen remained distended but soft. There was marked weakness. On the 6th day vomiting stopped, pulse and respiration increased, moist rales developed in the lungs, and the patient died.

Dr. Edwin Kay: The history states that she ate pork three days before admission, one day before the onset of symptoms. We have to think immediately of infection with trichinae but I believe that the constant vomiting, the type pain and the amount of distention together with the absence of eosinophils in the blood all tend to rule out trichiniasis.

This is apparently an acute abdomen — at least the surgeon in charge of the case thought so because he operated only a few hours after admission. Thus, a differential diagnosis of conditions causing an acute surgical abdomen or simulating it is indicated at this point and I submit the following:

1. Sudden peritoneal invasion with septic fluid.
 - A. Sudden pain all over the abdomen.
 - B. Profound shock with no tendency to recovery.
 - C. Intense tenderness and rigidity.
 Found in:
 - a. Rupture or perforation anywhere along the gastro-intestinal tract.
 - b. Ruptured appendix.

c. Ruptured gall-bladder.
d. Ruptured urinary bladder.
e. Rupture of previously localized abscess.

2. Hemorrhage in the peritoneum. Blood loss is a cardinal factor.
 A. Pain and shock is moderate and only proportionate to the degree of traumatism.
 B. Pallor, restlessness, rapid pulse and sighing respiration.
 C. Free fluid in the flanks.
 Found in:
 Ruptured liver, spleen, kidney, uterus, bloodvessels or ectopic pregnancy.

3. Intestinal obstruction. The peritoneal cavity is not affected at first and the shock usually passes off before peritonitis sets in.
 A. Constipation is absolute from the first.
 B. Vomiting going on to incessant vomiting characteristic of obstruction.
 C. Marked tenderness and abdominal rigidity are absent in the early cases.
 Found in:
 a. Strangulated hernia.
 b. Volvulus.
 c. Mesenteric thrombosis.
 d. Obstruction by foreign bodies.

4. Torsion, strangulation or acute inflammation of a viscus.
 A. The shock is less and more gradual.
 B. Pain is severe but usually preceded by some premonitory symptoms.
 C. Definite localization is usually the rule because the seat of pain is over some swelling or some area of resistance.
 Found in:
 a. Intussusception.
 b. Twisted renal or splenic pedicle.
 c. Twisted ovarian tumor.
 d. Acute pancreatitis.
 e. Strangulated hernia of a solid viscus.

5. Colic.
 There is no primary inflammatory lesion and the pain is due to distention of a duct or to abnormal muscular spasm.
 A. Agonizing pain over the affected part, intermittent, radiating. Sudden onset and sudden relief. Patient very restless.
 B. Rigid abdomen over the area.
 C. There is usually a history of an antecedent condition.

6. Non-surgical.
 Cholera, poisoning, tabes dorsalis and basal pneumonia.

Our case does not tell us what the surgeon did at operation. This would probably take away the fun of a discussion such as this.

We have a very sudden onset with vomiting which became incessant. Immediate pain was apparently not severe. We have absolute constipation, apparently. The progress notes do not state if the bowels moved post-operatively. The distention has remained marked. Rigidity has been absent. An immediate flat plate of the abdomen may have been of some help but the patient was apparently in too much shock.

All the symptoms and physical findings in this case can be obtained in intestinal obstruction.

Acute pancreatitis would be unusual in a picture as here. There is no history of previous gastric disturbance, no splinting or rigidity. The frequent bluish-gray discoloration of the face and abdominal wall is not mentioned. However, pancreatitis can give us very peculiar pictures and we must not rule it out too severely in the case at hand.

My first diagnosis is: Intestinal obstruction, high up.

Second choice: Acute pancreatitis.

Dr. Romeo A. Beliveau, *Pathologist:*

On the afternoon of the operation the surgeon found a badly infected gall-bladder which he opened and drained. A culture from the peritoneal fluid revealed colon bacilli.

At autopsy numerous soft, small, discreet yellow-white areas of fat necrosis were found on the omentum. The gall-bladder was open, its wall thickened, and the mucosa injected, with several small hemorrhagic areas. The pancreas was the organ concerned. It was soft, mottled, yellow-white. There were numerous

Continued on page 94

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County Society Notes

100% Paid Membership for 1947

Piscataquis County Medical Society
Waldo County Medical Society
Hancock County Medical Society
York County Medical Society

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, Wednesday evening, March 19, 1947.

Richard C. Wadsworth, M. D., of Bangor, spoke to the society on "Septospinosis."

J. H. Crowe, M. D.,
Secretary.

Kennebec

A regular meeting of the Kennebec County Medical Association was held at the Augusta House, February 28, 1947. President Frank Bull called the meeting to order at 7.30 P. M.

During the brief business meeting, Dr. Margaret Simpson, of Augusta, was admitted to membership by transfer from the Massachusetts Medical Society.

Dr. Shields Warren of Boston, recently a Captain in the U. S. Navy, was the speaker. He participated in the Bikini experiments and studied the effect of the atomic bomb at Hiroshima.

Dr. Warren spoke on "The Medical Aspects of the Atomic Bomb." He began by expressing the opinion that this country is technologically ten years ahead of the rest of the world, and it is absolutely essential that they keep ahead. He gave the distinct impression that it was important for the physicians to have a knowledge of the effects of atomic energy in order to handle situations in the future.

There are three main types of injury—

1. Those due to the air blast.
2. Those due to radium injury—flash burns.
3. Those from gamma rays.

Most important of the latter are immediate effects to all types of cells; later the effects on the white cells and next, that of the red cells.

Lastly the germinal epithelium is heavily hit, resulting in either sterilization or mutation.

He is impressed by the inadequate care on the part of the Japanese physicians.

He outlined four problems that he had been concerned with in dealing with atomic energy.

An adequate means of detection of the presence of ironization of radiation in the atmosphere: secondly, the diagnosis of the effect on the patient of the therapy in which radiation sickness must get special attention.

He brought out very clearly the incalculable importance of proper human relationships with special regard to the international phase. The implications with regard to the architectural changes and distribution of population are, to say the least, profound.

A question period followed.

Fifty members and guests were present at the dinner. Following the dinner District Nine of the Morticians' Association, which was holding a meeting in

the next room and had as guests our own members, Dr. Bristol and Dr. Mitchell, came in by invitation.

A. H. Morrell, M. D.,
Secretary.

Penobscot

A regular meeting of the Penobscot County Medical Association was held at Bangor, Maine, on Tuesday, March 18, 1947.

An afternoon session was held at the Eastern Maine General Hospital with presentation of cases and discussion by Dr. Raymond Adams, Neuro-Pathologist, Pratt Diagnostic Clinic, Boston. Dr. Adams presented a paper on "The Neuritides." Dr. Herbert Clough, Jr., read a paper on "The Newer Concepts of Disease Invasion."

In the evening, Dr. Martyn A. Vickers entertained the members of the Association and visiting doctors before the regular meeting.

Following dinner at the Bangor House, a regular business meeting was held. Medical society sponsored Prepayment Insurance Plans were discussed. Difficulty in receiving payment from the Veterans' Administration through the Associated Hospital Service was brought into open discussion.

Dr. Richard B. Cattell, Surgeon-in-Chief, Lahey Clinic, Boston, presented a paper on "Surgical Lesions of the Large Intestine."

The attendance was 52.

John E. Smith, M. D.,
Secretary.

News and Notices

Roscoe L. Mitchell, M. D., of Augusta, will retire as Director of the State Bureau of Health, May 1st. Dr. Mitchell, who has been connected with the Department of Health and Welfare since 1930, plans to return to private practice.

Byron F. Porter. M. D., of Caribou, Bureau of Health District Health Officer for District VI, retired on February 28th. Dr. Porter has been with the Bureau since 1925.

Charles F. Thomas, M. D., of Caribou, has been appointed District Health Officer for District VI, according to a recent announcement from the Bureau of Health.

State of Maine
Department of Health and Welfare
* * *
Preventive Service and Medical Care for Children

The State Bureau of Health announces that two new projects offering preventive service and medical care to children were started in March, 1947.

A school health program, with complete followup corrective service, was started in and around Machias. This school health project was developed by the State Bureau of Health and the State Department of Education coöperatively. Dr. John Kazutow, health officer in district V, will supervise the program. Local physicians agreed to give the physical examinations.

A hard-of-hearing program was started by the Division of Services for Crippled Children in a small area, i.e., Waterville, in coöperation with otolaryngologists in Waterville, Augusta and Gardiner, with Dr. Frederick T. Hill as chairman of this group and advisor for the program. The otolaryngologists are offering free service in the clinics which are staffed by a pediatrician, medical social worker and public health nurses. Treatment, speech therapy, and hearing aids, if indicated, will be provided by the Services for Crippled Children. Consultation service will be available through other divisions in the State Bureau of Health, such as dental consultation and consultation by the Division of Mental Health. It is planned to expand this program to other areas in the State in the near future.

Poliomyelitis Preparedness Meeting to be Held at the State House in Augusta, May 15, 1947

On May 15, the State Bureau of Health and the State of Maine County Chapters of the National Foundation for Infantile Paralysis are planning a poliomyelitis preparedness meeting at the State House in Augusta, according to a letter from Ella Langer, M. D., Acting Director, Division of Services for Crippled Children. Dr. Langer states that, "Experience has demonstrated the value of these preparedness programs sponsored by the state health departments in coöperation with the National Foundation. All are agreeing that those states which conducted such meetings were more adequately prepared to meet the needs in their states when cases of polio began to appear.

"A one-day meeting is planned in two sessions; one general session in the morning and two panel sessions in the afternoon, one for professional personnel and one for chapter personnel. Hart E. Van Riper, M. D., Medical Director of the National Foundation of Infantile Paralysis, New York City, agreed to attend the meeting. He will be most helpful to us in making a plan which would be fitted to the resources and needs of the State of Maine."

Specific program and hours will be available later.

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., 192 State Street, Portland, Secretary.

Physicians Licensed to Practice Medicine and Surgery in the State of Maine, March 12, 1947.

Through Examination

Edward William Davis, M. D., Naval Shipyard Dispensary, Portsmouth, N. H.

Richard N. Fallon, M. D., 43 Green Street, Augusta, Maine.

Edmund Parmelee Kelley, M. D., 15 Maple Street, Hopkinton, Mass.

Francis X. LoGalbo, M. D., Christ Hospital, Jersey City, N. J.
Robert Colton MacDuffee, M. D., 49 Western Promenade, Auburn, Maine.
Gerard Lucien Morin, M. D., Christ Hospital, Jersey City, N. J.
Thomas Paul Nangle, M. D., West Paris, Maine.
Joseph Marion Patane, M. D., Old Orchard, Maine.
Daniel Phinney Storer, M. D., 188-28 Linden Blvd., St. Albans, L. I., N. Y.
Poe-Eng Yu, M. D., Valley Forge General Hospital,Phoenixville, Pa.

Through Reciprocity

Philip L. Archambault, M. D., 13 Warren Ave., Lewiston, Maine.
Wilfred I. Butterfield, M. D., 147 Maple Street, Bangor, Maine.
Payson Bernard Jacobson, M. D., 73 Mountfort Street, Portland, Maine.
John Albert James, M. D., 32 Frye Street, Lewiston, Maine.
John Bernard Madigan, M. D., Houlton, Maine.
Lee W. Richards, Jr., M. D., 121 Bridge Street, Augusta, Maine.
Elmer Ames Shaw, M. D., Calais, Maine.
Hugh Allan Smith, M. D., 768 Union Street, Bangor, Maine.
Roland Gilbert Tremblay, M. D., Army and Navy General Hospital, Hot Springs, Ark.
Harland Glidden Turner, M. D., 8 Gannett St., Augusta, Maine.
Byron Van Vleck Whitney, M. D., 115 St. Stephen St., Boston, Mass.
John T. Wright, M. D., Boothbay Harbor, Maine. c/o Dr. Gregory.

National Gastroenterological Association Annual Session—June 4, 5, 6, 1947

The National Gastroenterological Association will hold its 12th Annual Convention and Scientific Sessions at the Hotel Chelsea in Atlantic City, N. J., on June 4, 5, and 6, 1947.

Program and details may be obtained from the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Narcotic Drugs Import and Export Act

Under the provisions of the Narcotic Drugs Import and Export Act, it is unlawful for a physician to carry narcotic drugs in his medical bag back and forth between the United States and Mexico and between the United States and Canada. Narcotic drugs found in the possession of a physician upon returning to the United States are seized and forfeited. Because of lack of knowledge of the law many physicians are caused embarrassment and inconvenience when travelling between this country and Mexico or Canada. This information is published in order that physicians may be correctly informed with reference to this provision of the Federal law.

Clinical Pathological Exercise—Continued from page 91

areas of fat necrosis throughout its substance. There were occasional areas of old hemorrhage on the surface, especially near the head.

The main points in pathological diagnosis were:

Acute Pancreatitis.
Toxic Hepatitis.
Acute and chronic Cholecystitis.

This condition is better called acute pancreatic necrosis, for there may be no hemorrhage and the lesion is much more necrotic than inflammatory. It occurs more frequently in obese individuals of middle life and most often characterized by a sudden onset usually following a heavy meal. About 65% of cases are in females and 60 to 70% give a history of previous gastro-intestinal disturbance.

The necrosis is due to pancreatic enzymes liberated from the ducts but the exact method of liberation is still undecided. It is commonly believed that the trypsinogen of the pancreas must come in contact with intestinal juice or infected bile before it is changed to trypsin which has the power to digest tissue. Opie's original impression was that obstruction of the ampulla of Vater either by a stone or a plug of mucus could easily cause a back-flow of bile into the pancreatic duct. We remember that it joins the common duct a short distance from its entrance into the duodenum.

More recently Rich and Duff[1] have found that pancreatic juice is able to produce necrosis without activitation of the trypsinogen with intestinal secretion or bile. They believe that obstruction of the duct may cause rupture and escape of the pancreatic secretion. This obstruction may be due to a stone or to squamous metaplasia of the lining epithelium of the smaller ducts. This lesion was present in over half of the cases they studied.

One particularly interesting aspect of these cases is the remarkable ability of the islands of Langerhan to withstand injury. We have seen several cases where microscopically the acini and ducts were completely destroyed but here and there could be seen seemingly well preserved islands.

The cause of death is apparently wholesale absorption of split proteins caused by partial digestion of pancreatic tissue.

1. Rich and Duff: *Bull.*, Johns Hopkins Hosp., 58: 212, 1936.



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SEARLE

RESEARCH
IN THE SERVICE OF MEDICINE

Gastrointestinal Bleeding—Continued from page 80

Case 6.

L. M., age fifty, admitted to the hospital with history of general abdominal discomfort over two years duration. It has increased during the past six months. There was nausea and vomiting, loss of weight, and no anemia. Roentgenological studies revealed 1.5 mass in the antrum of the stomach with a small ulcer crater along the lesser curvature. There was about ninety percent residue at the end of six hours. Gastric resection was done and pathological report was that of a malignant tumor and Dr. Porter and several pathologists thought it was of neurogenic origin. This case is presented as a possible leiomyosarcoma and this type of tumor is a frequent cause of hemorrhage. This type of tumor with ulceration is often difficult to demonstrate by Roentgen ray examination.

Case 7.

H. S., age sixty-seven, admitted to the hospital with a history of vomiting blood, loss of appetite and loss of weight over a period of a few weeks. Laboratory studies revealed a hemoglobin of fifty-five percent, 3, 2,000,000 red blood cells, 4, 300 white blood cells. Roentgen studies revealed a lesser curvature gastric ulcer and a duodenal ulcer. Patient was kept on an ulcer diet and re-examination revealed the gastric ulcer healed and changes in the duodenum suggesting a healing duodenal ulcer.

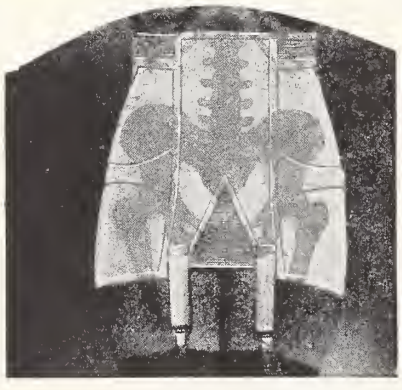
Discussion:

A group of one hundred seventy-five duodenal ulcers have been reviewed and fifteen cases were found out of this group with the presenting symptoms due to hemorrhage. In addition, several selected cases with gastric lesions have been presented as representative examples of the causes of gastrointestinal hemorrhage. Duodenal ulcer may occur at any age. In this series the youngest was age four and the oldest age seventy-eight. One patient, age thirty-eight, presented a problem in that the antral spasm made it difficult to demonstrate the gastric ulcer and it is important to note that this case was found to be malignant. Again, one case is presented which had the appearance of a benign gastric ulcer which showed evidence of healing under treatment but within one month increased in size, indicating that this was a malignant ulceration and the pathological report was that of adeno carcinoma.

Summary

A group of gastric and duodenal lesions have been reviewed with special attention to gastrointestinal hemorrhage. Some of the problems in Roentgen studies are emphasized and some of the difficulties in evaluating gastric ulcers as to whether or not they are benign or malignant is stressed.

From the Department of Roentgenology, Maine General Hospital, Portland, Maine.



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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, May, 1947 No. 5

*Group Practice and Changing Professional Relations in the Hospital**

Frederick T. Hill, M. D., D. Sc., Thayer Hospital, Waterville, Maine

Group practice may be defined as the pooling of professional and material resources, with the objective of more efficient medical service, economically advantageous both to patient and physician. It has been subject to more or less criticism, largely from within the medical profession, as being too elaborate for the ordinary type of illness, sometimes too costly, and as tending to create cliques and factionalism. It has been stated that often it provides substandard service from unqualified, self-labelled specialists, that it limits the choice of consultants and that there is a loss of the personal relationship between patient and physician. The validity of these criticisms depends, to a great extent, upon the type of group and the individuals composing it. Like the hospital, any group will be only as good, or as competent, as its physicians. And any such plan undertaken primarily for commercial reasons, either to increase the physicians' income or even to reduce expenses, would hardly merit being sponsored by the hospital. Similarly, any plan which limited the choice of consultants, or tended towards cliques based upon mutual self-interest could only meet with disapproval. The welfare of the patient always must be our first consideration.

Good Medicine, whether individual or group, should aim to provide the best possible diagnostic and curative service at a cost consistent with the patient's financial status. Illness should not entail economic catastrophe. Loss of earning power alone is enough of a burden to bear. Hospital insurance should be easily available to all employed persons through the Blue Cross or similar plans, and the hospitalization of the indigent properly should be met from general tax sources. The development of prepayment medical care insurance should lessen the burden of professional fees; but, whether or no, if Medicine is to retain its Time-hallowed reputation as the most humane of professions, it must not carry a price-tag. Fees, whether from group or individual physicians, should always be consistent with the patient's means.

While there are, of course, definite economic advantages through the pooling of material resources; to my mind, the greatest argument for group practice is in the improved quality of medical service that is made possible through the facilitating of consultations and of group

* Presented at the New England Hospital Assembly, Boston, March 12th, 1946.

study. The greatest value would seem to be in the increased emphasis upon coöperative professional effort, with better diagnoses and less delay in effecting proper treatment. How often do we see a patient with some obscure condition making the rounds of physicians until finally a diagnosis of carcinoma is made by the specialist in some particular field? Group study at the onset might have indicated the diagnosis and allowed for effective treatment before the condition became too advanced.

For years the larger teaching hospitals have embodied the principles of group practice in the care of their service cases. Perhaps the outstanding feature in our changing professional relations in hospitals has been the gradual, often unconscious, extension of these principles to all patients. It has been the logical thing to pool professional resources in the hospital. And it can and should be done in all hospitals. This implies group study of cases whenever indicated, the liberal use of consultations and transferals to other services, or physicians, if the patient would benefit thereby.

In our own hospital, we have gradually developed a system of coöperative effort in the care of the patient, which, while not strictly group practice, has resulted in such a pooling of professional resources. This has promoted better standards of medical service, provided better care of the patient and increased the scientific attitude of the staff. And the physicians like it and find it worthwhile.

This idea of coöperative practice works so well both for the patient and the physician, and is so logical and so productive of improved service, that it is bound to grow. There is great satisfaction for any physician in doing better, more efficient, more scientific work, such as is made possible by this pooling of minds and skills. It is one of the best means of attracting the desirable type of physician to the hospital. And those who will not subscribe to coöperation are not especially desirable and had best be eliminated. They will be far happier in other surroundings and the hospital will be better off without them.

The principle that the hospital should assume the responsibility for the safety and the medical care of its patients, both service and private, is becoming more generally recognized. The private patient is no longer to be considered the personal medical property of his physician. Rather he is the hospital's patient, under the care of the physician; but with the hospital, through its staff, responsible for diagnosis and treatment. The concensus of medical minds of the staff should be available to determine whether or not, proper treatment is being carried out. This may indicate the need of consultations, of additional diagnostic procedures, or a complete change of therapy, or even of physicians. At first hand, this may seem revolutionary to some, but if the patient is to be assured of the best care and the hospital is to live up to its responsibilities, this must be accepted.

And this, of course, is group practice in the hospital. And it's not new, or revolutionary. It's simply the adaptation to all patients in all hospitals of the accepted principles of what we have termed the teaching hospital, which has produced the best type of Medicine the World has ever seen.

In this connection, I dislike the designation "teaching hospital." All hospitals, regardless of size or location, should be teaching hospitals. In no other profession is a program of Continuation Education so necessary as in medicine. So often the recovery, the health or even the life of the patient depends upon the skill and knowledge of the physician. And medical science is not static. What better place to carry on a program of Continuation Education than the hospital, every day and every week? Any good hospital will have teaching material if only it is made use of. This should include private as well as service cases. Patients, as well as physicians, benefit from case study. Self-education, after all, is the most valuable form of education. To neglect this, substituting an occasional short course in some teaching center, is both lazy and wasteful. It is time we were weaned from an exclusive regimé of spoon-feeding. The weekly staff meeting, if properly planned and conducted, is one of the best forms of education. It can and should make all hospitals teaching hospitals. Hospitals will vary in size and in scope but all should strive for the same high ideals and have the same standards of service.

A logical step would seem to be the greater development of group facilities for diagnosis

prior to hospital admission, and the utilization of these facilities for ambulatory patients, not requiring hospitalization. If developed under the aegis of the hospital, this should be free of any taint of commercialism. There are sound professional and economic arguments for such a plan, such as readily available consultations, X-ray and laboratory facilities and the saving of the physician's time, a large portion of which is spent daily in the hospital.

I am not particularly concerned with just how this is done, provided the main objective of better diagnoses be achieved. Local conditions must be the determining factors. The full-time salary plan has certain advantages and also is open to certain criticisms. Many physicians are, by nature, rugged individualists and object to anything smacking of regimentation. And this plan calls for expert administration to succeed. In some circumstances the use of group offices in the hospital on a rental basis, with the unit system of fees for cases seen by the group, might be desirable. The fee should be based upon; first, the value of the service to the patient, considering his financial status; and second, the relative value of the services of the several physicians concerned. This type might be more adaptable to a group which was to include a number of older, well-established physicians. And as patients could come first to the physician of their choice, the personal relationship would be preserved. It is just a more efficient method of getting consultations, eliminating the psychological and economic barriers that often prevail.

The scope of such a group will, of course, vary according to the size of the staff and the various specialties represented. The small community hospital staff may consist entirely of general practitioners, with perhaps one man doing part-time X-ray work. Despite these limitations such a group could practice more efficient medicine than by working individually. Consultants from larger centers could be utilized when necessary. And as the need developed it would not be so difficult to attract specialists in different fields.

At the same time it is not necessary, and indeed may not be desirable, to include the entire staff membership in suh a plan. There may be physicians serving the hospital most satisfactorily who might not be especially useful for the purpose of the group, or who would not care to become affiliated with it. A good working unit, including as many specialists as is possible, should be the objective, and members should be selected for their particular ability. With larger staffs the senior men ordinarily would be the natural selections, with the younger men serving in junior capacities. Services might be rotated, just as in the hospital. But these are details to be solved on the local level.

The main thing is to provide better professional service, both in the hospital and for the ambulatory patient, to substitute coöperation for competition, and to do this without imposing undue financial burden on the patient. And, above all, to accomplish this by a method devoid of political or bureaucratic control. It would seem a natural and logical development for the voluntary hospital.

John Dewey, in his "Human Nature and Conduct," states that there is a sort of social arteriosclerosis that sometimes leads to degeneration and decadence in institutions. This comes not necessarily from age but from rigid and petrified customs that prevent growth and adjustment. He suggests that if institutions be kept flexible and plastic in habits they need never grow too old to function well, but that constant infusions of new blood and new ideas are required to keep them young and that sometimes they need to change their structures, or to purge themselves of complacency in order to hold their place or even survive.

Might not these words of Dewey be applicable to our hospitals? If so, we could well give careful consideration to possible changes in structure and habits aimed at a more efficient program for the care of the sick.

Many a maternity patient has received obstetric care in its most literal sense — that is, care which is focused only on her reproductive organs — and died from tuberculosis or diabetes or cancer soon after delivery. Hazel Corbin, R. N., *Jour. of Nursing,* Aug., 1946.

Delayed Obstetrical Labor

K. Alexander Laughlin, M. D., Portland, Maine

The two most common causes for delayed labor are contracted pelves and uterine inertia. These two conditions are of such great importance that the physician himself dreads the thoughts of them and so many times seeks what he considers the easier way out of things, namely, Caesarean Section. Although there is some danger incident to natural childbirth, certainly the dangers are much greater when the labor is terminated by some operative procedure. When one interferes the risks of maternal and fetal mortality are increased so greatly that an honest effort should be made to deliver the patient by natural process, and artificial means should be employed only when it is essential to the welfare of the mother or baby.

With a clearer understanding of contracted pelves and uterine inertia, we may be able to lower the incident of operative procedure and, therefore, lower the maternal and fetal mortality rate.

The estimation of pelvic contractions by clinical means utilizes simply two measurements which are rarely attempted, namely, the diagonal conjugate and the bisischial diameters. The other measurements are useful only in classification of pelves according to type. We have various types of calipers which can measure pelves with more or less accuracy, as well as elaborate roentgenologic technic. Serious attempts have been made in the past ten years to popularize X-ray pelvimetry. The numerous procedures that are being used are in themselves evidence that no one method is beyond criticism, and highly trained roentgenologists, themselves, recognize the technical difficulties, with the result that it is not always dependable. The average practitioner whose knowledge of roentgenology is limited can more easily determine the size of pelves by the use of the fingers and hands. This method is more easily attainable and less costly, not only in dollars and cents, but in maternal and infant mortality.

In determining the two most important measurements, namely, the diagonal conjugates and the bisischial diameters, no elaborate pelvimeter is necessary. The diagonal conjugate, which bears no mathematical relation to the external conjugate, extends from the under margin of the synphysis pubis to the promontory of the sacrum. The examining finger is pressed with some force against the vulva while the middle finger at a thirty-five degree angle points upward until the promontory of the sacrum is reached. If the promontory of the sacrum is not reached, we can say in general that the pelvic inlet is greater than 11.5 centimeters and therefore adequate.

The other important measurement is that of the outlet, or the bisischial diameter. Many physicians believe that after the presenting part is engaged the danger of contraction of the outlet is minimal and their trouble is at an end. But, how many times have we seen extremely difficult low forcep extractions and complete perineal tears. All this could be avoided if only the simple procedure of placing the fist between the two ischial bones is used, and if the four-finger clenched fist fits easily between them, we know that the outlet is over 8 centimeters and adequacy exists. If the above is unable to be accomplished and only three fingers can be invaginated, there may be some slight mechanical difficulty at the outlet; and when two fingers fill the space elective Caesarean section may be the procedure of choice.

In the average population of New England, significant contractions of the pelvis do not exceed 2.5 per cent, and at least half of these patients will deliver readily through the vagina. The remainder should have elective Caesarean sections. For a physician to perform Caesarean sections late in the course of prolonged labor because the "bones are too small" is to acknowledge the unsatisfactory character of the antepartum care. Proper pelvic measurements should have detected the contraction before the onset of labor and should have indicated a safer delivery procedure.

Another frequent cause of delayed labor is uterine inertia. This slow progress is commonly ascribed to a contracted pelvis or to a rigid cervix. The former is relatively rare, while the "rigid cervix" probably does not exist as an

Continued on page 112

Maternal Pulmonary Embolism by Amniotic Fluid

Report of a Case

Irving I. Goodof, M. D., Lewiston, Maine.

From the laboratories of the Central Maine General Hospital and the Bingham Hospital Extension Services.

Maternal Pulmonary Embolism by Amniotic Fluid

In 1941, Steiner and Lushbaugh[1] reported eight cases of pulmonary embolism by amniotic fluid. They suggested that this hitherto undescribed pathologic entity would account for a number of previously unexplained deaths occurring during labor and the early puerperium, as well as many complications of delivery noted during life. The clinical picture was that of shock, often following unusually severe uterine contractions. Dyspnea and cyanosis were observed, followed by a rapid weak pulse, and death. Clinical diagnoses in their cases were: obstetric shock, acute failure of left heart, postpartum hemorrhage (3 cases), abruptio placentae with postpartum hemorrhage, placenta previa and thyrotoxicosis, and ruptured uterus or abruptio placentae. The outstanding clinical observation was the occurrence of extremely severe uterine contractions, uterine tetany, or sudden, forceful, unexpected expulsion of the baby.

In all instances autopsy revealed distention of the pulmonary arterioles and capillaries with epithelial squamae, mucus, and meconium. An identical anatomical lesion was produced in rabbits and dogs by intravenous injection of human amniotic fluid and meconium.

Two cases were added by the same authors in 1942.[2] One of these lived seven days after delivery and the onset of symptoms, and was found to have rupture of the uterus in addition to pulmonary embolism by amniotic fluid. The other was delivered by Cæsarian section through the placenta. In each of these cases, the degree of embolism was far less than that observed in the previous eight, suggesting that massive embolism depends on strong contractions, although embolism may occur in the absence of uterine contractions if another route is provided.

Since no further instances of this condition have appeared in the literature, the following case is presented.

Case Report*

A forty-year-old woman was admitted to the Rumford Community Hospital with a diagnosis of pregnancy at term. Pregnancy had been uneventful, with regular prenatal examinations revealing no pathological findings. There had been six previous normal deliveries, without complications. One child died in infancy.

The membranes ruptured four hours before admission to the hospital. Active labor began seven hours after rupture, lasted three hours, and terminated in a normal spontaneous delivery of a dead baby, apparently strangled by the cord. No medication was administered during labor. Ether was used during delivery. While on the delivery table, the patient complained of severe pain in the right hip, radiating down the right thigh.

Pitocin (1 cc.) was administered after delivery of the placenta, and ergotrate (1 cc.) one-half hour later. Two hours following delivery the patient began to cough and wheeze. The cough was dry and nonproductive. She vomited bile-colored fluid once while coughing. Cyanosis developed and was not relieved by oxygen, morphine, and atropine. Respiration became more difficult, and the patient expired. The clinical impression was pulmonary infarct and ? pulmonary edema.

Autopsy revealed a well developed woman showing marked cyanosis and abundant white frothy fluid exuding from the nose and mouth. The internal genitalia were consistent with the immediate postpartum period. The maternal

* Permission to publish this case kindly granted by Dr. P. B. Aucoin.

sinuses were dilated, the wall of the uterus edematous, and several masses of placental tissue remained in the cavity of the uterus.

The lungs were heavy and wet. Large amounts of white frothy fluid were easily expressed from the cut surface. Careful examination of the major pulmonary vessels revealed no gross evidence of embolism or other pathological change. Because embolism by amniotic fluid was suspected, numerous blocks of lung were fixed for sections. All of these sections showed an identical picture. The pulmonary arterioles were massively distended with plugs of epithelial squamae, mucus, meconium, and numerous polymorphonuclear leucocytes and lymphocytes. The appearance was identical with that seen in the sediment from amniotic fluid. Other organs showed no pathological change.

Discussion

The causes of unexpected postpartum deaths have long been poorly explained. Hemorrhage, "shock," and placental abnormalities have been proposed as lethal factors in many instances in which they were actually present in only minor degree. The recognition of the above described entity supplies an explanation for some of these catastrophes. The condition should, in many instances, be recognizable clinically, and, at least in mild cases, treatment of the pulmonary edema and spasm of pulmonary vessels may result in prolongation of life beyond the period of organization of the emboli.

Summary

A case of embolism of amniotic fluid and its contents to the maternal pulmonary vasculature is described. Recognition of this entity explains some instances of unexpected postpartum death.

References

1. Steiner, P. E., and Lushbaugh, C. C.: *Maternal Pulmonary Embolism by Amniotic Fluid. J. A. M. A.*, 117:1245-1254 and 1340-1345, October, 1941.
2. Lushbaugh, C. C., and Steiner, P. E.: *Additional Observations on Maternal Pulmonary Embolism by Amniotic Fluid. Am. J. Obs. and Gyn.*, 43:833-838, May, 1942.

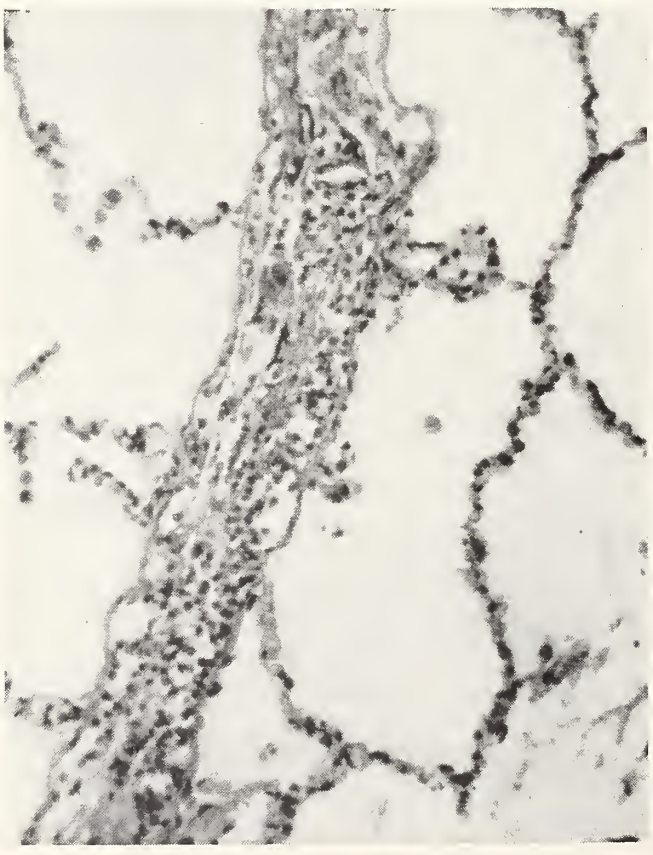


Figure 1: Distended pulmonary arteriole, filled with mucus, epithelial squamae, and leucocytes (x 200).

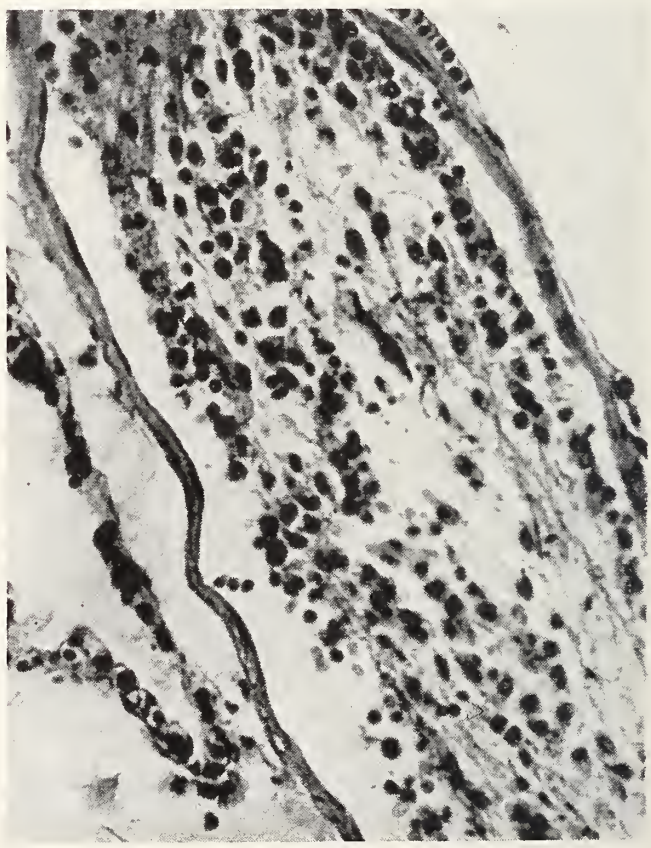


Figure 2: Same (x 600).

Clinico-Pathological Exercise

Neurological Case Presented at the Maine General Hospital, Portland

Edited by Joseph E. Porter, M. D., Portland

This is the case of a 33-year-old white male who entered this hospital with the chief complaints of fever and generalized aches and pains of 7 days' duration. He was apparently quite well until about 5 years prior to admission, when he noted the onset of an aching pain in his left upper chest in a fairly restricted area about 4 cm. below the clavicle, in midclavicular line, and also beneath the sternum at the level of the 2nd and 3rd ribs. Over the next 3 years these attacks occurred several times, and on each occasion would last for about a month and then disappear. About 3 years prior to admission these attacks began to be accompanied by a fainting sensation which occurred either in the late afternoon or evening. He never actually fainted. This sensation often occurred while he was in bed, and prevented his sleeping. He had a feeling of complete exhaustion with each attack, and experienced a tingling sensation in his left arm and sometimes in his left leg. Nausea was often present, but he seldom vomited. About 3 years prior to admission the patient became troubled with frequent neckaches which would cause nausea and severe headaches. Subsequently, X-rays of the cervical spine revealed the presence of an extra cervical vertebra. Physio-therapy was instituted and the patient experienced considerable relief. About 1½ years prior to admission his headaches recurred, and were accompanied by considerable nervousness. After some months they began to occur as often as every 10 days and became so severe that the patient had to go to bed for several days after each attack. He went to his LMD, who gave him some injections and put him on a diet. There was some improvement following this, but whenever he went off his diet he became very upset and uncomfortable. Later he began to complain of a pressure sensation in his stomach region, and inability to sleep at night. Over a period of about 6 months leading up to the present admission, he became increasingly more nervous and sometimes had palpitation. In addition, there sometimes occurred attacks of what he described as "all gone" feelings, which occurred quite frequently and upset him greatly. His neckaches continued to occur with less severity and frequency. His headaches were described as radiating from his eyes, through his head, and down the back of his neck. Ten days before admission, he complained of a sore throat, which lasted a few days and then disappeared. Seven days prior to admission he began to ache all over and developed a fever. In addition, he was troubled with a severe headache which seemed to center across the eyes and radiate down to his neck. The right side of his neck bothered him the most. On the 5th day prior to admission, he noted the onset of nausea, but no vomiting. He was seen by a LMD, at this time, who found nothing abnormal except fever, and treated him symptomatically. However, he failed to improve, and was admitted to this hospital.

Past History: Measles at age of 15 years. He was thought to have had the flu at age of 19; at this time he was unconscious for a 4-day period. He was under the care of a physician, who could find no cause for this event. Subsequently, he stayed in bed for a month and was returned to work apparently well. Tonsillectomy and submucous resection at age of 24 years. Appendectomy at 25 years of age. He had astigmatism, for which he was fitted with glasses. Married, and wife is alive and well; two children, living and well. Family history not obtainable.

Physical Examination on admission revealed a well-developed but poorly nourished thin male, who appeared mildly ill. Temperature 101°; pulse 90/min.; B. P. 130/90. Head, neck, and nose not remarkable. Eyes: Pupils equal, round, and active; E. O. M. normal. Mouth: Tongue coated, throat slightly injected. Chest long, thin, asthenic; moved equally and adequately. Heart: Apex beat in 6th space, 6.5 cm. to left of mid-sternal line, and 4 cm. inside M. C. L. Heart sounds of good quality, no murmurs heard. Lungs: Clear to percussion

and auscultation. Abdomen: Flat, thin, no masses; no involuntary spasm, no areas of tenderness. Liver, spleen, kidneys not felt. Skin clear. Extremities essentially negative. Reflexes equal, active, physiological. Rectal examination: Prostate small; deep median fissure; no masses; no hemorrhoids.

Laboratory: Hb. 83%, 12 gms.; RBC 4,060,000; WBC. 10,150. Differential: Neutrophils 70%, eosinophils 2%, basophils 1%, lymphocytes 25%, monocytes 2%. Sedimentation rate 34 mm./hr. Kahn and Hinton negative. Urinalysis: Clear; yellow; specific gravity 1.026; no albumin, sugar, acetone, or diacetic; no casts; rare WBC.; rare RBC.

An X-ray of the chest on admission showed an area of increased density extending outward from the left border of the heart, which had irregular margins. The patient was started on sulfamerazine in full dosage. By the 4th hospital day his temperature had fallen to nearly normal, and he felt considerably improved, although he continued to complain of headache at times, and some malaise. He had also developed a loose cough. Sulfamerazine was stopped on that day. On the 6th hospital day he complained of a little numbness in his left hand; this persisted during the day, and by evening he was having some difficulty in manipulating his left hand and forearm, but had good use of the upper arm. On the 7th hospital day, he developed a complete flaccid paralysis of the left upper extremity, with practically no sensation. The deep reflexes were preserved. There was partial paralysis of the left lower extremity, but he was still able to move the ankle and toes slightly. Sensation to pinprick was present, but was lost later on in the day. The deep reflexes were preserved. Ankle clonus was present; the Babinski was questionable. The patient was lethargic and could be roused only with some difficulty, and when so aroused complained of a headache above the eyes. As the day wore on he began to develop some asymmetry of the face, with relaxation on the left side. The tongue protruded to the left, and the left pupil became smaller than the right, although both reacted to light. The temperature rose to 102.2°. A blood count done at this time was reported as follows: Hb. 78%, 11.3 gms.; RBC. 3,980,000; WBC. 28,350, with differential of 33% band form neutrophils, and mature polys 58%; lymphocytes 6%; and monocytes 3%.

X-ray at this time reported that the increased density which was previously described in the left chest had almost entirely disappeared and there now remained only a slight increase in the hilus region. There was no evidence of pathology seen. Right lateral stereo of the skull showed an area of diminished density in the anterior portion of the right parietal bone, which stereoscopically was seen to be partly due to an area of increased density in the left parietal bone superimproved on this area. The sella was normal; the pineal was seen in the lateral view to be in normal position. The mastoids appeared normal. Two lumbar punctures were performed on this day, the first at 9.30 A. M., which revealed an initial pressure of 300 mm. of water. There was a good response bilaterally to jugular pressure. The fluid appeared crystal clear. Laboratory: RBC. 1, WBC. 88; differential: 9% lymphocytes, 91% neutrophils. Smear showed no organisms. Total protein 100 mg.; reduction present; globulin slightly increased. The second lumbar puncture was performed at 5 P. M. The initial pressure was 100 mm. of water; fluid slightly cloudy; RBC. 20, WBC. 460, with 100% neutrophils. No organisms were seen. Reduction present; globulin slightly increased; total protein 100 mg.; quantitative sugar 57 mg. %. Colloidal gold: 0001221000. Cultures of both specimens were subsequently reported as negative. Later on in the evening of the same day the patient went to operation.

On the 8th hospital day, he suddenly developed acute pulmonary edema. He was placed in an oxygen tent, and an airway was inserted, with some improvement. A cisternal puncture was performed and reported as follows: RBC. 30, WBC. 486, with 56% neutrophils, 40% lymphocytes, 4% monocytes; globulin 3+; total protein 100 mg%; quantitative sugar 115 mg. %; reduction present. No organisms were seen in the smear; the culture was negative. Within 7-8 hours following the initial onset of pulmonary edema the patient improved, and by evening of the same day it appeared to be almost entirely gone. However, the patient had not responded since the operation. On the 9th day his pulse and temperature began to climb slowly but steadily. A blood count on the 11th hospital day showed: Hb. 95%, 13.7 gms.; RBC. 4,430,000; WBC. 20,300, with differential of 6% band form neutrophils, 85%

mature polys, 8% lymphocytes, and 1% monocytes. The patient remained unresponsive. By the 11th hospital day his temperature was 106° and pulse 155, and respirations 35. He was operated on for the second time on the evening of this day, after an E. N. T. consultant had reported no evidence of middle ear infection. Following operation his course continued downhill. His cardiac action throughout the night became weaker and his respirations progressively more difficult. His temperature climbed to 106.4° and his pulse to 150. He expired on the 12th hospital day. Repeated blood cultures taken during the course of his hospitalization were reported as negative. The patient never responded after the first operation on the 7th hospital day.

DISCUSSION

Dr. George Maltby: This 33-year-old white male comes into the hospital with an illness of seven days' duration, consisting of fever and generalized aches and pains. In the past history the only things that seem to be of importance is that he had suffered from some severe pain in his chest 3 years ago. He seemed to feel faint, although he never actually fainted. The history of frequent leg aches may also be a pertinent factor. Another point that may have some importance is that at the age of 19 he had influenza and was unconscious for 4 days. All the symptoms leading up to his immediate illness seem to have little to do with his present trouble, which began with a sore throat, lasted a few days, and then disappeared. He also complained of frontal headaches which radiated from the frontal region down into his neck. Five days prior to admission, he complained of nausea, but no vomiting. He was treated by a local physician, who found no abnormalities other than his fever, and treated him symptomatically. Because of his failure to improve, he was admitted to the hospital.

Examination on admission showed the following pertinent things: His temperature was 101° and his pulse 90. Otherwise his general physical examination seemed to be negative. His lungs were said to be clear. Laboratory work on admission showed elevation of his white count and approximately normal sedimentation rate, and his urine showed a rare RBC. and rare WBC. X-rays of his chest on admission showed an area of increased density outward from the left border of the heart, which was believed to be a pneumonic process, and because of this the patient was started on sulfamerazine. After 4 days in the hospital his temperature fell to normal, and he seemed to improve, although he complained of some headaches. The sulfa drug was stopped on this day.

It seems to me that the onset of his neurological difficulties occurred on the 6th hospital day, when he complained of some numbness in his left hand, persisting through the day, and by evening he had lost most of the use of his left hand and forearm. However, on the next day, he developed a flaccid paralysis of the left lower extremity and the paralysis of his left hand was more severe. During that day he seemed to have less sensation over the left side of his body, and he developed a left ankle clonus and questionable Babinski sign on the left. The patient became drowsy and difficult to arouse. He continued to complain of headache. He then developed a left-sided facial weakness and his right pupil began to dilate. His temperature became elevated to 102°, and his WBC. went to 28,000. X-ray examiner reported that the chest condition had almost completely cleared. The X-rays of the skull are said to be within normal limits. The mastoids appeared normal.

On the 7th day in the hospital two lumbar punctures were performed. The initial pressure was elevated to 300 mm. of water. Fluid was clear. However, there were 88 white cells, 91% of them being neutrophils, 9% lymphocytes, total protein was 100 mg. %. A smear was negative, and sugar was normal. A second lumbar puncture on the same day showed a pressure of only 100 mm. of water, and the total protein was still 100 mg. %. The cell count was 460 WBC., 100% polys. Colloidal gold curve had a few 1's and 2's in the mid zone. Cultures on both specimens were reported as negative. The evening of this day an operation was carried out. On the 8th hospital day, the patient developed pulmonary edema and was placed in an oxygen tent. Cisternal puncture was done, which showed 48 white cells, 56% polys. Total protein was again 100 mg. %, and quantitative sugar was normal. Since the operation, the patient did not respond, and on the 9th day the vital signs began to fail. His temperature on the 11th day rose to 106°, his pulse went down to 55, and his respirations were 35. This time a second operation was done, after the ear, nose,

and throat consultant had reported no evidence of middle ear disease. In spite of this, his condition continued downhill. The patient never responded after the second operation, and died on the 12th hospital day.

Here we have a patient who comes into the hospital with what seems to be an acute upper respiratory infection, which probably was complicated by pneumonia. This seems to clear, but as he is improving, he suddenly developed left-sided neurological signs, which progressed into a complete left hemiplegia. Unquestionably he had a lesion in his right cerebral hemisphere, probably in the frontal-parietal region, possibly with involvement of the internal capsule. What was this lesion, and what would be considered in the differential diagnosis? It seems to me that he did not have meningitis of the infectious type, because of his negative smears, cultures, and normal sugars. The spinal fluid picture is not that of tuberculosis or luetic meningitis. It seems to me that the best possibility in this instance is a localized intracranial infection, possibly brain abscess or cerebritis. The temperature is unusually high for a brain abscess. It might be this high in a cerebritis, which, after all, is nothing but the precursor of a brain abscess. Could this be something metastatic from his chest, either abscess, or even tumor? I believe that a mycotic embolism must be considered. It seems to me that it would be extremely unlikely to see a toxic encephalitis with such extremely localized signs.

Dr. Maltby's Diagnosis

1. Brain abscess in the early stages, right parietal region, with the possibility of this being metastatic from the lungs.
2. Metastatic brain tumor is a possibility, but a cell count like this would be extremely unusual in a brain tumor.

Anatomical Diagnosis

1. Hemorrhagic encephalitis.
2. Bronchopneumonia.

Dr. Porter: This is a fairly diffuse encephalitis, which is characterized by the presence of numerous hemorrhages, particularly in the white matter, and you will notice in Illustration No. 1 that the process is most marked in the basal ganglia on the right side, which accounts for the predominance of symptoms on the patient's left side. You will notice that the process in Illustration No. 2 has extended down to involve the pons. The basal ganglia on the right side, in addition to being hemorrhagic, were softer than on the opposite side. On micro-

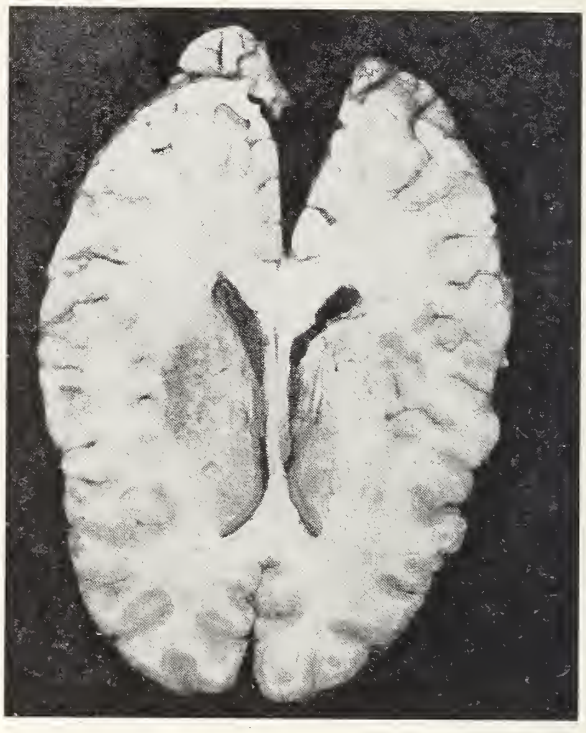


Illustration No. 1

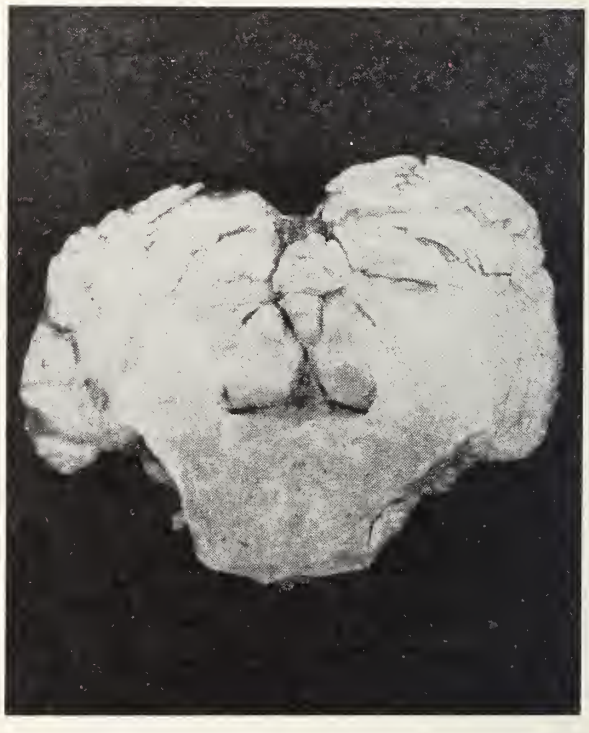


Illustration No. 2

Continued on page 109

The President's Page

There are two matters I wish to mention at this time.

The first one is regarding the Child Health Service in our State.

No doubt you have received forms to fill out, giving this information, but, strange as it may seem, only 60% of the general practitioners in Maine have filled in this form and returned it to its proper authorities. This percentage is not large enough to establish reliable statistical data from the category of the general practitioner.

This study is authorized and supported by the A. M. A. and the State Societies throughout the country.

The data when completed, will be a valuable reference as to what is being done for the children in our United States.

Forms to fill out have been sent to all the M. D.'s in our State, but if they have been lost or misplaced, I am informed that a second copy has already been sent to those who have failed to send one in. Should a third one be needed, it can be obtained by sending a request to 196 Cumberland St., Brunswick, Maine.

Please attend to this, as it takes only a few moments of one's time, and is really valuable.

The other matter I wish to speak of is the Annual Meeting of the Maine Medical Association, to be held in the Marshall House at York Harbor.

This is certainly one of the most beautiful spots in the State to hold a meeting.

I believe the Program that has been arranged is exceptionally good. The entertainment planned for the women is splendid.

Please keep the dates of this meeting in mind, June 22, 23, and 24, and prepare to spend these few days listening to good medical entertainment. Get your reservations early.

JOHN O. PIPER, M. D.,
President, Maine Medical Association.

Editorials

The Ninety-Third Annual Session

The 93rd annual session of the Maine Medical Association will be held at The Marshall House, York Harbor, Maine, June 22nd, 23rd, and 24th.

Dexter E. Elsemore, M. D., of Dixfield, Chairman of the Scientific Committee, and members of his committee, have spent much time and effort in arranging a very fine program, which is published in brief elsewhere in this issue. The complete program will be published in the June issue of the JOURNAL.

Stephen A. Cobb, M. D., of Sanford, President-elect, will officially call the session to order at 3.00 P. M., Sunday, June 22nd, when the House of Delegates, the legislative body of the Association, will assemble. According to the Association By-Laws each County Society is entitled to send one delegate, or one corresponding alternate, to the House of Delegates for each twenty-five full paid members or fraction thereof. Therefore each County Society has an equal vote in any action taken by the House. We urge a 100% attendance of Delegates at both meetings of the House—the importance of this is self-evident. Members who are not delegates are invited to attend meetings of the House of Delegates and to enter into any discussion before the House, although not entitled to vote.

The Second Meeting of the House will convene at 5.30 P. M. on Monday, June 23rd. Election of Councilors for the Third and Fourth Districts will be on the Order of Business for this meeting.

Carl E. Richards, M. D., of Alfred, is arranging a special program for the ladies, which will be published in the June issue of the JOURNAL.

York Harbor is one of Maine's scenic spots; The Marshall House one of its most beautiful resort hotels; the program arranged for you speaks for itself — so make your reservations now and plan to spend these few days with your colleagues, combining "business with pleasure."

Shortage of Institutional Nurses

Any discussion today of the professional care of patients in any hospital concerns itself preeminently with the difficulties with which the hospital is faced. And, as hospitals differ in type of service rendered, in personnel policies, in equipment, so do their problems differ. But there is one difficulty common to all, there is one problem all must face. That is the shortage of nurses.

Never, even during the worst period of the war, has the situation been worse. Nurses are simply not available. Not just in Maine, but nationally there exists a critical shortage of student nurse candidates, student nurses and—the ultimate effect—professional, trained nurses.

The result of this is inadequate nursing care, especially in hospitals. It is obvious that this situation may seriously affect the health and welfare of our communities by (1) closure of hospital beds; and (2) curtailment of many non-emergency operations.

We, as doctors, should be concerned with this problem, for in the face of this difficulty are the increased medical and surgical needs of our people, the necessity for providing more and more urgently needed hospital care.

For by "hospital care" we clearly mean a sufficiently high maintenance of good nursing care to preclude any jeopardy of the patient's recovery.

There have been many reasons advanced for the shortage of professional graduate nurses. Among the foremost are (1) increased demands for general hospital care by patients, probably resulting from the increasing trend to buy prepaid hospital care; (2) demand for profes-

sional nursing in industry; (3) the shorter work day; (4) the difficulty hospitals have in matching the advancing salaries offered in industry; (5) the various projects of the Federal government and the Veterans' administration.

Since the curtailment of the Cadet nurse program sponsored by the Federal government, there has been a universal fall in enrollment in nursing schools throughout the country. We, in Maine, have felt this keenly. Many young girls who formerly might have gone into nursing hesitate at this time to spend three years in training without knowing more certainly of the advantages which might accrue to them after completing such a course.

The nursing staff and physicians, more than other members of the hospital family, have carried the load of work during the trying war years. Their members were drastically depleted by the Armed Forces and the defense plants. In many cases the students have had to carry the nursing load. To add to their burdens has been the inability of the hospitals to obtain sufficient and competent subsidiary help. But where are their replacements?

As you well know, there is a general shortage of female help everywhere in the country. Because of this a large number of girls who have only a high school education find regular employment at a salary greater than they might have expected to get after completing a three-year course in our schools of nursing. It is our feeling that such an advantage is only temporary, and that a girl who is interested in her future can expect more permanent financial returns and definite security in the nursing profession. Furthermore, there is a certain prestige associated with nursing, which is classified as one of the professions, and on the completion of her work the good nurse will have a feeling of satisfaction in a job well done.

The cost of the average nurse's training is relatively small as compared with a college education, and there are innumerable opportunities offered to the nurse for further study in her field, with the possibility of obtaining a college degree.

It has been suggested by many that hospitals adopt two grades of nursing and use the so-called practical nurse to a greater extent. There is little doubt that many institutions will have to supplant and augment some of the nursing service in this manner, but regardless of the type of aide program adopted by our hospitals, it will be necessary for them, particularly the larger ones, to continue their student nurse programs in order to furnish a nurse of high calibre to carry on the further training of these aides and to take the executive positions in the hospitals.

Now under way is an American Hospital Association sponsored national program of nurse recruitment designed to alleviate this critical condition. But it remains for we who participate in and guide our community's health program to stimulate community interest in relieving this unfortunate situation.

To epitomize the present situation in the hospital, one can say that a greater number of people are constantly seeking care in our hospitals. At the present time the availability of nursing personnel with which to provide even just adequate care is not only not increased, but lessened. Therefore, we urge that members of the medical profession, through their every-day community contacts, do all they can to enlist young girls in their communities to try nursing as a profession.

Clinico-Pathological Exercise—Continued from page 106

scopic examination the process is similar in all sections, and consists of varying degrees of perivascular hemorrhage. There were no thrombosed vessels seen, and there was no leukocytic infiltration found about any of the vessels. This condition is a toxic hemorrhagic encephalitis, which might be due to a number of different causes. However, in this case, I feel that it could be explained on the basis of sulfonamide therapy, and is similar to the cases described by Roseman and Airing in 1941.[1, 2]

References

(1) "Encephalopathy Associated with Sulfamethythiazole Therapy," Roseman, E., and Airing, C. D., *New England Journal of Medicine*, 224: 416, 1941.

(2) "Cerebral Vascular Changes Associated with Azosulfamide and Sulfamethythiazole Therapy," Scheinker, I. M., *Journal of Neuropathology and Experimental Neurology*, 2:301, 1943.

PROGRAM IN BRIEF

Maine Medical Association

Ninety-Third Annual Session

THE MARSHALL HOUSE

York Harbor, Maine

SUNDAY, MONDAY AND TUESDAY

June 22, 23, 24, 1947

SUNDAY, JUNE 22, 1947

3.00 P. M.

First Meeting of the House of Delegates

7.00 P. M.

Dinner

8.30 P. M.

Guests Speakers:
To be announced

MONDAY, JUNE 23, 1947

Morning Session

9.00 A. M.

General Assembly:
President John O. Piper, M. D., presiding

Announcements:
Dexter E. Elsemore, M. D., Chairman, Scientific Committee

Frederick R. Carter, M. D., Secretary

CONFERENCES

9.30 A. M.-12.00 M.

I

ANESTHESIA

Chairman: Gilbert Clapperton, M. D., Lewiston

Subject: "Spinal Anesthesia"

II

EAR, NOSE AND THROAT

Chairman: Frederick T. Hill, M. D., Waterville

Subject: Panel Discussion—"Deafness"

1. Causes and Types
 George O. Cummings, M. D., Portland
2. Prevention
 Pierre Provost, M. D., Augusta
3. Conventional Procedures in Treatment
 Henry P. Johnson, M. D., Portland
4. Hearing Aids
 John E. Whitworth, M. D., Bangor
5. Fenestration
 Merton N. Flanders, M. D., Waterville

III

GENERAL MEDICINE

Chairman: Theodore E. Hardy, M. D., Waterville

Subject: Panel Discussion — "Metabolic Diseases"

IV

ORTHOPEDICS

Chairman: Thomas A. Martin, M. D., Portland

Subject: To be announced

V

GYNECOLOGICAL—OBSTETRICAL

Chairman: Theodore C. Bramhall, M. D., Portland

Subject: "Sterility"

1. General Discussion
 Theodore C. Bramhall, M. D., Portland
2. Anatomical and Special Tests of the Female Genital Tract
 Magnus F. Ridlon, M. D., Bangor
3. Endocrinology
 K. Alexander Laughlin, M. D., Portland
4. Urological
 Donald F. Marshall, M. D., Portland

Luncheon

12.30 P. M.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill, Vermont, Tufts, Yale and Harvard Medical Schools, and members of the Tumor Clinics.

Afternoon Session

2.00-5.00 P. M.

Scientific Session

1. Treatment of Acute Complications of Diabetes
 G. G. Duncan, M. D.
2. Management of Obstructive Jaundice
 Richard B. Cattell, M. D.,
 Boston, Mass.
3. The Problem of the Ruptured Intervertebral Disc
 George F. Maltby, M. D.,
 Portland

5.00 P. M.

Election of President-elect

5.30 P. M.

Second Meeting of the House of Delegates

Evening Session

7.00 P. M.

Dinner

Guest Speaker: **Winthrop Adams, M. D.**

Subject: "Medical and Hospital Care of Veterans under Veterans' Administration

TUESDAY, JUNE 24, 1947

Morning Session

9.30 A. M.-12.00 M.

CONFERENCES

I

Annual Meeting of the Maine Medico-Legal Society

Speakers:

LeMoyne Snyder, M. D., Medical Director of the Michigan State Police, Lansing, Mich.

A. Warren Stearns, M. D., Department of Sociology, Tufts College, Medford, Mass.

II

Allergy

Chairman. Martyn A. Vickers, M. D.,
Bangor

1. Food Allergy
 Abraham Colmes, M. D.,
 Boston, Mass.
2. Pediatric Allergy
 Edward O'Keefe, M. D.,
 Lynn, Mass.
3. Allergy in Relation to Diseases of the Skin
 Martyn A. Vickers, M. D.,
 Bangor

III

Eye

Chairman: Warren E. Kershner, M. D.,
Bath

Speaker: **Howard F. Hill, M. D., Waterville**

IV

General Surgery

Chairman: Edward L. Herlihy, M. D.,
Bangor

Subject: Symposium on Gall Bladder Disease

1. Anatomy and Newer Physiological Concepts
 Howard R. Ives, M. D.,
 Portland
2. Surgical Gall Bladder Disease and Diagnosis
 Waldo A. Clapp, M. D.,
 Lewiston
3. X-ray Studies of the Gall Bladder Tract
 Hugh Smith, M. D.,
 Bangor
4. Operative Procedure
 Clyde I. Swett, M. D.,
 Island Falls
5. End Results of 100 Cases
 Richard T. Munce, M. D.,
 Bangor

V

Urology

Chairman: Joseph Memmelaar, M. D.,
Bangor

VI

Pediatrics

Chairman: Glidden L. Brooks, M. D.,
Lewiston

1. State Services for Children
 Ella Langer, M. D.,
 Augusta

 Discussed by Thomas A. Foster, M. D.,
 Portland
2. Influenzal Meningitis
 Philip G. Good, M. D.,
 Portland

 Discussed by Glidden L. Brooks, M. D.,
 Lewiston
3. Pyloric Stenosis
 Gerald H. Donahue, M. D.,
 Presque Isle

 Discussed by Albert W. Fellows, M. D.,
 Bangor
4. Anesthesia in Children
 Gilbert Clapperton, M. D.,
 Lewiston

 Discussed by Magnus F. Ridlon, M. D.,
 Bangor

OVER

5. A Case of Rh Incompatibility
 Rudolph Toch, M. D., and Theodore S. Golden, M. D.,
 Lewiston
 Discussed by Joseph E. Porter, M. D., Portland

Afternoon Session

2.00-5.00 P. M.

Scientific Session

President's Address
John O. Piper, M. D., Waterville

2. Prophylthiouracil
 E. B. Astwood, M. D., Boston, Mass.

3. Diagnosis and Treatment of Mediastinal Tumors
 Richard H. Sweet, M. D., Boston, Mass.

Evening Session

8.00 P. M.

Annual Dinner

Presentaion of Fifty-Year Medals by President John O. Piper, M. D.

Guests Speakers:

Governor Horace A. Hildreth

Professor Julius S. Bixler, Colby College, Waterville

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Luncheon	2.50
Dinner	3.00
Banquet	3.00

MAKE YOUR RESERVATIONS EARLY

Delayed Obstetrical Labor—Continued from page 100

entity except when surgical procedures on the cervix, especially in high amputations, have produced a hard annular scar with little or no elasticity. The concept of cervical rigidity as an explanation for lack of cervical dilation is too thoroughly ingrained in the profession to be easily eradicated, because it is easier to place the blame on an anatomic structure than to tell the suffering woman that she is "not having sufficient pain to do any good." Still, it is common knowledge that such cervices dilate readily as soon as truly effective pains appear.

The best treatment for uterine inertia consists of first, patience; second, sedation; and third, efforts to maintain proper water balance and nourishment. The first is undoubtedly the hardest to acquire and yet it should be remembered that prolongation of labor itself rarely leads to any serious harm, while operative intervention before the cervix is completely dilated definitely increases the risk to mother and child. Morphine sulphate grains ⅓, repeated as often as indicated to encourage rest, is probably the best drug we have at the present time. This dosage tends to increase the uterine tone as well as the contractions. The pharmeological action of this drug is not to stop contractions as formerly thought, and this idea should be abandoned. Fluids must be given in sufficient amounts to combat the tendency to dehydration. The febrile reactions which we see in so many of these cases and which are attributed to exhaustion are nothing more than dehydration fever. They are treated best by intravenous saline solution or isotonic dextrose. Isotonic solutions should be emphasized because in giving solutions as 5 percent dextrose in normal saline, we are dealing with a hypertonic condition depleting the patient's fluid balance.

The use of oxytocic drugs to whip up the uterus carries an element of risk to both mother and child which cannot be ignored. Rapid delivery produces more harm to the baby than a slower and more normal birth with intracranial hemorrhage as a sequalae. Thousands of infants are actually killed annually by the use of these oxytocic drugs; and when autopsies are not performed routinely, but the death certificates read repeatedly "pulmonary atelectasis" or "congenital heart disease," it makes one wonder.

This paper has been written in the attempt, first, to have physicians who are practicing obstetrics make use of the simple pelvic measurements which alone can tell us the nature of the pelvis. The second purpose has been to emphasize the employment of patience, fluids and sedation in treatment of uterine inertia.

"often gives dramatic relief..."

Writing on treatment in congestive heart failure, Eggleston[1] states: "The slow intravenous injection of 0.25–0.5 Gm. of Aminophyllin often gives dramatic relief."

1. Eggleston, C., in Cecil, R. L.: A Textbook of Medicine, ed. 6, Philadelphia, W. B. Saunders Company, 1943, p. 1154.

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County Society Notes

Cumberland

A meeting of the Cumberland County Medical Society was held at the Maine General Hospital, Portland, Maine, on April 28, 1947. After a brief business meeting the speaker, Dr. Allan S. Butler of the Harvard Medical School, was heard on pending Federal legislations. He enumerated various Federal legislations concerning medical care, and compared the National Health Act of 1947, sponsored by Senator Taft, possessing the backing of the American Medical Association, with the Wagner-Murray-Dingell Bill. In his opinion the Taft bill is a much more socialistic one than the Wagner-Murray-Dingell Bill, which has been condemned by the medical profession in general. One reason is that under the Taft bill the administrator can be a political appointee, by the President, and while he must be an M. D., he need not have had any previous training in health administration. Under the Wagner-Murray-Dingell Bill the Surgeon General of the U. S. Public Health Service would be the administrator. It was Dr. Butler's feeling that a man who had been in this work and made a career of it would be a much more adequate representative of the medical profession, and the job would be much less of a political one than under the new Taft bill. Dr. Butler also pointed out that out of the 6 principal parts of the Wagner-Murray-Dingell Bill, 5 have already been passed in various forms and are now in operation, including the Hill-Burton Bill, the National Science Foundation Bill, the Maternal Child and Health Bill, and others. He also emphasized the difference in the manner of coverage and taxation; in the Wagner-Murray-Dingell Bill those covered by the bill were definitely stated and the money would be raised by special taxation. Under the Taft bill the entire cost will come from the general fund, and the percentage of the population requesting aid under this bill is an unknown factor. The paper seemed to be enthusiastically received, and was discussed by Drs. Zolov, Thomas Foster, and James Parker.

Dinner was served at the hospital at 6.45 P. M., and preceding this a very interesting clinic, consisting predominantly of diabetic problems, was presented, and the discussion was opened by Dr. Butler.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, on Wednesday, April 23, 1947, at 6.30 P. M.

Donald F. MacDonald, M. D., of Bangor, discussed "Hemorrhage in the Last Tri-mester of Pregnancy and in Labor." This was followed by a round table discussion.

J. H. CROWE, M. D.,
Secretary.

Kennebec

A regular meeting of the Kennebec County Medical Association was held at the Elmwood Hotel, Waterville, Maine, on Wednesday, April 16, 1947.

Dinner at 6.30 P. M. was followed by a brief business session at which the minutes of the preceding meeting were approved.

Mr. W. Mayo Payson, Executive Secretary of the Maine Medical Association, discussed legislative affairs. He referred to the bill for an enabling act for Prepaid Medical Care, and to the financial difficulties faced by the bill for a medical school.

Dr. John O. Piper, President of the Maine Medical Association, spoke on the same general subject.

Dr. Hugh Smith, Associate Roentgenologist at the Eastern Maine General Hospital in Bangor, gave an illustrated talk entitled "Uterotubography—An Aid in the Diagnosis of Sterility."

Dr. Joseph Memmelaar, of Bangor, spoke on the subject "Some Thoughts on Hematuria."

Both papers were informative and well discussed.

A typical April snowstorm made hazardous going but nevertheless twenty-one got there.

A. H. Morrell, M. D.,
Secretary.

Penobscot

The Penobscot County Medical Association held its regular monthly meeting at Bangor on Tuesday, April 15, 1947.

A social gathering was held at the home of Dr. Edward L. Herlihy at 5.15 P. M. for the purpose of meeting visiting doctors.

Dinner at the Bangor House at 6.30 P. M. was followed by a brief business meeting.

Dr. Chevalier L. Jackson, Professor of Broncho-Esophagology, Temple University Medical College, Philadelphia, was the guest speaker. His subject was "Contributions of Broncho-Esophagology to General Medicine."

There were 84 members present.

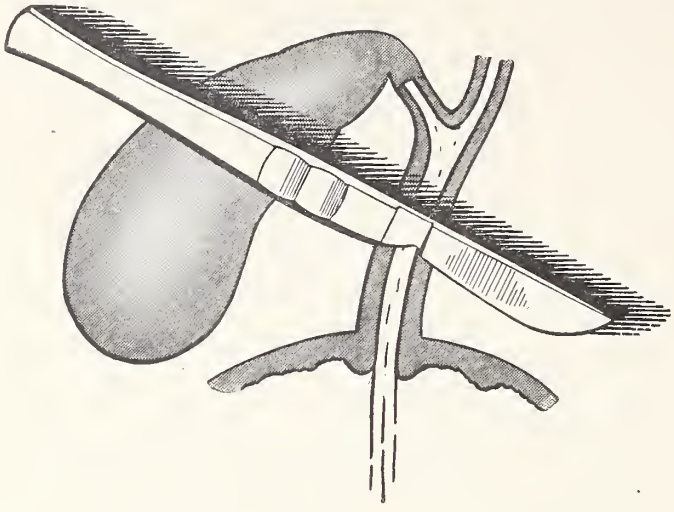
J. E. Smith, M. D.,
Secretary.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.



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News and Notices

News and Notices

Stephen A. Cobb, M. D., of Sanford, President-elect of the Maine Medical Association, was chosen Vice President of the Council of the New England State Medical Societies at the second annual meeting of the society held in Boston, April 16, 1947.

Harold A. Pingree, M. D., of Portland, Surgeon-in-Chief of the Children's Hospital since 1936 and one of three men instrumental in establishing it in 1908, will resign June 30th.

Dr. Pingree, whose resignation was accepted April 23rd, has been appointed Medical Advisor to the Board of Managers. He will continue to serve the hospital as a member of its consultive staff, as well as maintaining his private practice.

Thomas A. Martin, M. D., of Portland, has been appointed Surgeon-in-Chief of the Children's Hospital, to succeed Harold A. Pingree, M. D., whose resignation becomes effective June 30th. Dr. Martin will continue as Chief of Orthopedic Service for the Maine General Hospital.

Book Reviews

"National Formulary VIII"

The Council of the American Pharmaceutical Association is pleased to announce that the new, completely revised and enlarged National Formulary is available. This edition, the eighth published by the American Pharmaceutical Assocation since 1888, provides official specifications for many widely used drugs not previously included in either the U. S. Pharmacopoeia or the National Formulary. Copies of the new edition may be obtained from the Mack Publishing Company, 20th and Northampton Streets, Easton, Pennsylvania, at $7.50 per copy.

One hundred and eighty-eight new admissions have been added to the revised N. F. VIII.

To facilitate the use of the new arrangement, a marginal index is included throughout the book. This is only one of several innovations in the new National Formulary.

The Eighth Edition of the National Formulary represents the culmination of four years of planning and work by the members of the Committee on National Formulary, the staff of the American Pharmaceutical Association Laboratory, and hundreds of collaborators connected with college, governmental, institutional and industrial laboratories.

The new N. F. VIII becomes official April 1, 1947.

"The Management of Fractures, Dislocations, and Sprains"

By: John Albert Key, B. S., M. D., St. Louis, Mo. Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's and Jewish Hospitals; and H. Earle Conwell, M. D., F. A. C. S., Birmingham, Ala. Orthopedic Surgeon to the Tennessee Coal, Iron and Railroad Company, and the American Cast Iron Pipe Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopaedic Surgeons: Member of the Fracture Committee of the American College of Surgeons. Associate Surgical Director of the Cripped Children's Hospital, Attending Orthopaedic Surgeon to St. Vincent's Hospital, South Highlands Hospital, Jefferson-Hillman Hospital, Children's Hospital and Baptist Hospitals, Birmingham, Alabama.

Fourth Edition.

Published by the C. V. Mosby Company, St. Louis, 1946. Price, $15.00.

This book is divided into two parts: Part One, Principals and General Aspects; Part Two, Diagnosis and Treatment of Specific Injuries.

It contains twenty-five chapters. This is a most comprehensive textbook on the management of fractures and sprains. It is exceptionally well illustrated, and is an excellent reference book and should be in the library of all who are dealing with traumatic injuries.

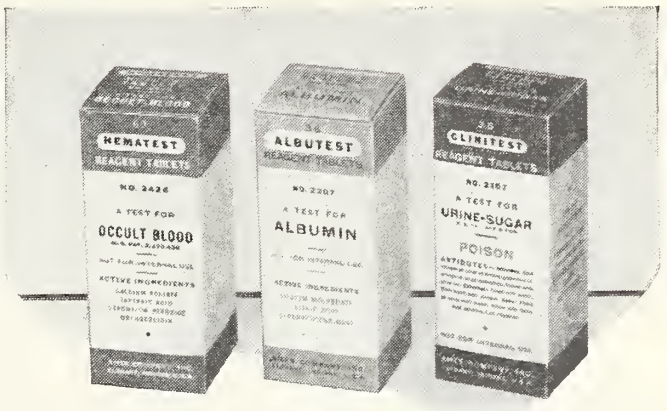
"Synopsis of Pathology"

By: W. A. D. Anderson, M. A., M. D., F. A. C. P. Professor of Pathology and Bacteriology, Marquette University School of Medicine; Pathologist, St. Joseph's Hospital, Milwaukee, Wisconsin; formerly Associate Professor of Pathology, St. Louis University School of Medicine.

741 Pages with 327 Text Illustrations and 15 Color Plates.

Published by The C. V. Mosby Company, St. Louis, 1946. Price, $6.50.

This book has twenty-five chapters which have been revised and brought up to date. Many changes and additions have been made. Emphasis has been given to "Tropical Diseases" and "War Medicine." The references given at the end of each chapter are well selected from available literature of recent years for those who wish to investigate the subject more thoroughly.



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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, June, 1947 No. 6

A Review of Recent Progress in Otorhinolaryngology

Merton N. Flanders, M. D., Thayer Hospital, Waterville, Maine

The Common Cold

The most significant progress in the prevention of the common cold is the development of the Influenza Virus Vaccine A-B. The Army Medical Corps and other large groups have endorsed its use, and surveys credit its effectiveness at 70% or better. Proetz[1] reviews the changes in physiology that help to precipitate coryza while Fabricant[2] has discussed the changes in Ph of the nose incident to the common cold. Drug concerns, following the trend of thought, have adjusted the Ph of sulfonamides for intranasal use to conform to the Ph of the normal healthy nose. Actually sulfa drugs and penicillin are not effective in preventing the common cold per se, or in treating it. They may be useful in inhibiting the secondary invaders that cause complications.

Penicillin and Sulfonamides

McMahon[3] calls our attention to reports of the biologic resistance of the micro-organism to sulfa drugs and antibiotics. He attributes this resistance to a natural characteristic of certain bacteria or an acquired property resulting from small inadequate dosages and refers to the research work of Abraham Chain, Rommelkamp, Maxon, McKee and Hauck who have developed resistant strains in vitro. Their conclusions were that the practical clinical application of this phenomenon lies in its potentialities regarding the transmission in epidemic proportions of sulfonamide and penicillin resistant micro-organisms of unattenuated virulence through a community; since such bacteria do not lose their sulfonamide-resistant qualities, but do require increased virulence by animal passage.

Sinusitis

The application of sulfa drugs and antibiotics to sinus infection has been presented in the medical literature from many views. Some of these views are divergent, nevertheless, most writers agree that the primary consideration in treatment is to promote intranasal drainage by the most conservative means possible. Small doses of sulfa drugs and penicillin particularly when administered intermittently are to be condemned because of their tendency to increase the resistance of bacteria and to favor the masking of symptoms and recurrences.

Vasoconstrictors in the Nose

Boyd and Connell[4] have found that the use of amphetamin (Benzedrine) as an inhalor gave relief from nasal congestion but did not shorten the length of the common cold. Excessive use of these sympathomimetic compounds can lead to toxic reactions[5] and a "chemical rhinitis." Tuamine, an aliphatic amine, is prepared in both the volatile form for the inhalor or in the aqueous solution for drops or spray. It is not an excitant to the central nervous system and does not induce insomnia if used at bedtime. The effect on blood pressure is minimal, thus offering a greater degree of safety to hypertensive individuals. Proetz[6] has found that therapeutic doses of tuamine have no deleterious effect on activity of mucous membranes.

Application of Intranasal Medicaments

Cawthorne[7] in an ingenious experiment, contrasts the efficacy of the "head low position" used in administering drops against "sprays," "sniffs" and drops given during indifferent or "head back" positions. In the dorsal recumbent position with the head hanging over the edge of the bed or couch, so that the vertex is pointing toward the floor, contact with the whole of the accessible nasal mucous membrane is possible. Drops instilled slowly, while in this position, are carried by gravity to the sinus openings. Furthermore, the medication is kept in contact with the membranes long enough to have effective action. For certain adults the lateral recumbent position with head hanging over the edge of the bed may be more comfortable. The dependent nostril is instilled. Later the position is changed to the other side and the procedure repeated on the other nostril which is now dependent.

Allergy

Experimental and clinical observations over a period of years have led to the assumption that anaphylactic shock and allergy are both caused by the release into the system of a substance which is now believed to be histamine. Fell, Marshall and Rodney[8, 9] have prepared a histamine azoprotein (hapamine) possessing the ability of stimulating the development of some degree of immunity to histamine. The previous preparations such as the chloride and the diphosphate had but little antigenic properties. McLaurin[10] has treated vasomotor (allergic) rhinitis with satisfactory results. Using histamine azoprotein he has also treated other syndromes which have been related to histamine sensitivity, such as vertigo (Meniere's Syndrome); periodic headache (migraine) and histamine cephalgia. Various allergic skin reactions were favorably effected.

Benadryl has been described by Thacker[11] as a palliative measure to be used until the physician can definitely determine the proper therapeutic regimen to follow. His investigation proved it to be effective in about 50% of cases of vasomotor and perennial rhinitis. It should not be given for several days preceding cutaneous testing for allergy because the effect may interfere with the wheal and pseudopodia formation. Side effects may include one or more of the following conditions from a mild to a marked degree; sleepiness, dryness of mouth, nervousness, vertigo, weakness, epigastric distress and diarrhea.

Pyribenzamine, according to a preliminary report by Goodhill,[12] does not have as many unpleasant side effects as benadryl. It will cause only occasional sedation, occasional slight vertigo and rare nausea. It is particularly effective in the relief of itching and sneezing and, to a lesser extent, allergic nasal congestion and rhinorrhea. Like benadryl it is an antihistamine and not a sympathomimetic.

Aerosolized Penicillin in Bronchial and Lung Suppurations

The beneficial effects are recognized to be diminution of the amount of bronchial secretions and offensive odor due to the reduction of penicillin-sensitive organisms. It has been most effective in acute and subacute infections. However, this type of treatment can mask intrabronchial tumors by clearing suppuration secondary to the obstruction. Methods are discussed by Holinger and Andrews.[13]

Tuberculosis of the Larynx

In a preliminary report on 4 cases, Figi and Hinshaw,[14] using aerosolized streptomycin,

were able to clear up tuberculous laryngeal ulcers and improve lesions in the lung parenchyma. Streptomycin may cause a toxic reaction in the labyrinth and eighth nerve[15] manifested by vertigo and tinnitus. Three of the four cases presented were so affected.

Adenoid and Lymphoid Hyperplasia

Middle ear changes secondary to eustachian tube obstruction and precipitated by sudden changes in altitude is known as "aerotitis" to the Army Air Forces Medical Corps. Using the method devised by Crowe[16, 17, 18] (radium irradiation with nasopharyngeal applicators) 74% of the cases[19] had less difficulty ventilating their ears during flight and 89% had a marked decrease in the amount of nasopharyngeal lymphoid tissue after a third treatment of irradiation. Adenoidectomy if indicated should be done prior to irradiation. Radium irradiation therapy of the nasopharynx has much to offer children with recurrent otitis media in whom the lymphoid growth seems impossible to suppress.

Local Use of Penicillin in Vincent's Angina and Tonsillitis

Hopp[20] reports 24-hour cures for Vincent's infection of the tonsil using penicillin pastilles. His cases of acute follicular tonsillitis had a return of body temperature to normal in twenty-four hours and marked symptomatic relief. Cure was obtained in three to five days. Penicillin pastilles are also used in Vincent's gingivitis and other dental infections.

Post Tonsillectomy Hemorrhage

Neivert et al,[21] in a series of cases, has shown the preoperative plasma concentration of ascorbic acid to be below normal in 54.5% and, in addition, 11.3% acquired a vitamin C deficiency after tonsillectomy. There were about five times as many hemorrhages among vitamin C deficient patients as there were among those with normal postoperative levels of ascorbic acid. Neivert[22] recently demonstrated that salicylate-induced hypoprothrombinemia is one of the most important factors in late tonsillar hemorrhage. Both vitamin K and ascorbic acid when given with acetylsalicylic acid eliminates the prothrombinopenic effect of the latter. In some European countries where acetylsalicylic acid is not used following tonsillectomy, secondary hemorrhage and hemorrhagic diatheses into the soft palate are seldom seen.

Tonsillectomy and Anterior Poliomyelitis

Cunning[23] feels that the widespread alarm on the part of the public, and shared by doctors in some communities, is unfounded on the basis of his statistics. In a study, carried out at the Manhattan Eye, Ear and Throat Hospital, on 11,204 tonsillectomy patients over a seven-year period, only four cases of poliomyelitis developed following tonsillectomy. None were of the bulbar type. The mode of transmission and the portal of entry of the virus of poliomyelitis remain unknown. Without this knowledge we are forced to theorize on the relationship between tonsillectomy and poliomyelitis. Roberts[24] has investigated the statistics of the State of Connecticut and presents figures comparable to the figures of Cunning.[23] He estimates that for an average of the entire United States a maximum incidence of polio following tonsillectomy to be approximately 1 in 100,000 cases. This compares quite favorably with the average annual incidence of polio in everyday life at 1 in 3,250 of population.

Acute Otitis Media

A properly performed myringotomy under aseptic preparations never permanently injures the drum or the ear as a hearing organ. It establishes drainage, a primary fundamental of surgery. Early employment of sulfonamides and penicillin are of great value but their masking effect on symptoms and signs must be kept in mind. Relapses following pencillin and sulfa drugs cause a more rapid destruction and are masked. Serial X-rays will help to inform the physician of bone necrosis.

Chronic Suppurative Otitis Media

Penicillin has not distinguished itself in the treatment of this condition and the reference to its use in the literature is mostly of negative value.[25, 26, 27, 28] Brown and Kelemen[29] report excellent results from using Glycerite of Hy-

drogen Peroxide in their cases. A reasonable supplement to their instruction is the gentle dry swabbing of the external canal before instillation of drops.

Otitis Externa

Investigations by Syverton[30] and by Senturia[31] reveal that fungi were isolated from only a small per cent of their cases. It was admitted, however, that it was possible that the fungi when present might be one of the primary agents of the infection. Many strains of bacteria are commonly found in a single infection, perhaps the most common being the gram negative bacilli, notably the pseudomonas group. Staphlococci and streptococci are often present. While the local use of penicillin has not been beneficial, large doses, parenterally, have been useful when the local reaction has been intense and accompanied by pain and fever. It is reasonable to assume that the cause of the intense symptoms are penicillin-sensitive organisms. The local use of penicillin may cause a dermatitis in the already macerated canal wall and is to be condemned. The local use of streptomycin would seem to be of benefit against the gram negative bacilli. As this antibiotic becomes more available, favorable reports may appear in the literature.

Tinnitus Aurium

Lempert[32] suggests that tinnitus often is associated with the tympanic plexus. In a series of 15 operations to remove the tympanic plexus he reports complete relief in 10 cases. This symptom as an integral part of Meniere's Syndrome will be relieved as more effective treatment for the syndrome is discovered.

Meniere's Syndrome

It is generally accepted that Meniere's Syndrome is due to hydrops of the labyrinth although we can only theorize as to the cause of the increased intralabyrinthine pressure. Atkinson[33, 34] divides the treatment of the syndrome into two groups; one, considered histamine sensitive, receives desensitization treatment, while the vasoconstrictor group receives nicotinic acid.

Day[35] fenestrates the lateral semicircular canal in a surgical approach and inserts an electro-coagulating needle into the vestibule of the labyrinth. This procedure destroys the labyrinth but is a safer and simpler approach than Dandy's section of the vestibular portion of the eighth nerve. McLaurin advises desensitization with histamine azoprotein. Lempert does the fenestration operation and in addition makes a window through the bony promontory of the middle ear. The recent methods devised for treatment of Meniere's Syndrome have the same object as the older treatments; that is to decrease intralabyrinthine pressure.

Otosclerosis

Surgery offers a hope for the return of useful hearing in specially selected cases of otosclerosis. Good hearing by bone conduction in the conversational frequency ranges and suitable physical conditions, both local and general, are essential. Lempert, who has perfected the operation to its present status and has been, directly and indirectly, responsible for teaching all of the surgeons doing fenestration surgery in this country, quotes the most conservative figures of successes. His cases must retain useful practical hearing for a period of two years and longer before he will consider them a success. Of the specially selected cases operated on without any misadventure he estimates that about 60% will be a success but he admits that he is unable to predict which of these cases will be among the successful group.

Hearing Aids

The otologist, from one examination and audiogram, can usually predict whether or not a hearing aid is going to be useful to a deaf person. It must be remembered that the hearing aid amplifies not only the conversational sound that the deafened person wants to hear but also many unpleasant extraneous noises. He must learn to ignore these loud and distracting sounds by patient and persevering efforts. It is essential that an ear-piece be made to fit his own external auditory canal, otherwise leaks and "feed-back" sounds will weaken and mask the reception of conversation. With his own ear-piece the prospective buyer of a hearing aid can "shop around" before making his final

choice. In selecting a hearing aid inquiries should be made concerning the repair services that are available. A hearing aid that can be repaired locally is to be preferred over one that has to be sent a long distance. The instrument which gives the best results for one person may not help another. And the expense of the instrument is no criteria of its performance.

References

1. Proetz, A. W.: Nasal Physiology and Common Cold. *Annals*, Vol. 55:308 (June), 1946.
2. Fabricant, N. D.: Clinical Significance of the Ph of Superficial Mucous Membranes of the Head. *Eye, Ear, Nose and Throat Monthly*, 23:219, 1944.
3. McMahon, B. J.: The Influence of the Sulfonamides and Antibiotics on the Future of Otorhinolaryngology. *Annals of Otorhinolaryngology*, Vol. 55:298 (June), 1946.
4. Boyd, E. M., and Connell, W. F.: Vasoconstrictor Properties of Benzedrine and Its Use in the Relief of the Common Cold. *Am. J. M. Sc.*, 194: 678-682 (Dec.), 1937.
5. Boyd, E. M.: The Effect of Benzedrine on Ciliary Movement. *Am. J. M. Sc.*, 196:44-46 (July), 1938.
6. Proetz, A. W.: 2 Amino-Heptane Sulphate as a Nasal Vasoconstrictor. *Annals Otology, Rhinology and Laryngology*, 51:112-116 (Mar.), 1942. Certain Aliphatic Compounds as Nasal Vasoconstrictors. *Arch. Otolaryng.*, 37:15-22 (Jan.), 1943.
7. Cawthorne, Terence F. R. C. S.: Intranasal Medication. An Investigation into the Relative Merits of Certain Methods of Introducing Fluids into the Nose. *The Annals*, Vol. 55:519 (Sept.), 1946.
8. Fell, Norbert; Rodney, Gertrude; and Marshall, D. E.: Histamine-Protein Complexes: Synthesis and Immunologic Investigation. I. Histamine Azoprotein. *Jour. Immunol.*, 47:237, 1943.
9. Rodney, G., and Fell, N.: Histamine-Protein Complexes: Synthesis and Immunologic Investigation. II. B-(5-Imidazolyl)-Ethyl Carbamide Protein. *Jour. Immunol.*, 47:251, 1943.
10. McLaurin, J. W.: Desensitization by Histamine (Histamine Azoprotein) in Vertigo, Periodic Headaches and Vasomotor (Allergic) Rhinitis. Review of the Literature and Report of 102 Personal Cases. *The Laryngoscope*, 56:253 (June), 1946.
11. Thacker, E. A.: Evaluation of Benadryl as a Therapeutic Agent for Vasomotor and Allergic Rhinitis. *Arch. Otolaryng.*, 43:597 (June), 1946.
12. Goodhill, V.: Pyribenzamine in Allergic Rhinitis (Preliminary Report). *The Laryngoscope*, 56:687 (Nov.), 1946.
13. Holinger, P. H., and Andrews, A. H., Jr.: Review of the Literature of 1945 Pertaining to Broncho-esophagology. *Laryngoscope*, 56:1 (Jan.), 1946.
14. Figi, F. A., and Hinshaw, H. C.: The Treatment of Tuberculosis of the Larynx with Streptomycin. *Transactions Am. Acad. of Oph. and Otol.*, 93 (Nov., Dec.), 1946.
15. Brown, H. A., and Hinshaw, H. C.: Toxic Reaction of Streptomycin on the Eighth Nerve Apparatus. *Proc., Staff Meeting*, Mayo Clinic, 21:347-352 (Sept. 4), 1946.
16. Crowe, S. J.: The Prevention of Deafness in Children. *Laryngoscope*, 49:59, 1939.
17. Crowe, S. J., and Baylor, J. W.: The Prevention of Deafness. *J. A. M. A.*, 112:585-590, 1939.
18. Crowe, S. J., and Burnam, C. F.: Recognition, Treatment and Prevention of Hearing Impairment in Children. *Annals of Otology, Rhinology and Laryngology*, 50:15-31, 1941.
19. The Use of Radium in the Aerotitis Control Program of the Army Air Forces. *The Annals of Otology, Rhinology and Laryngology*, 54:650-723, (Dec.), 1945.
20. Hopp, E. S.: Penicillin in the Oral Therapy of Vincent's Angina and Acute Follicular Tonsillitis. *Archives of Otolaryng.*, 44:409 (Oct.), 1946.
21. Neivert, H.; Pirk, L. A.; Engelberg, R.: Late Secondary Tonsillar Hemorrhage. *Archives Otolaryng.*, 43:568 (June), 1946.
22. Neivert, H.: Late Secondary Tonsillar Hemorrhage. 1. Studies of Prothrombin and Vitamin K. *Arch. Otolaryng.*, 42:14-18 (July), 1945.
23. Cunning, D. S.: Tonsillectomy and Poliomyelitis. *The Annals of Otol., Rhin. and Laryng.*, 55:583 (Sept.), 1946.
24. Roberts, E. R.: Tonsillectomy and Poliomyelitis. *Annals*, 55:592 (Sept.), 1946.
25. Struble, G. C.: Penicillin Therapy in the Practice of Otolaryngology. *Arch. Otolaryng.*, 42:327 (Nov., Dec.), 1945.
26. Conley, J. J.: Treatment of Chronic Suppurative Otitis Media with Penicillin. *Arch. Otolaryng.*, 42:374 (Nov., Dec.), 1945.
27. Smith, A. T.: Clinical Use of Penicillin in Infections of the Ears, Nose and Throat. *Arch. Otolaryng.*, 43:12 (Jan.), 1946.
28. Loeb, W. J.: Penicillin Ear Drops in the Treatment of Suppurative Otitis Media. *Arch. Otolaryng.*, 43:586 (June), 1946.
29. Brown, E. A., and Kelemen, G.: The Use of Glycerite of Hydrogen Peroxide in Inflammatory Aural Conditions — Clinical Report. *The Laryngoscope*, 56:556 (Sept.), 1946.
30. Syverton, J. T. et al.: Otitis Externa. *Arch. of Otolaryng.*, 43:213 (Mar.), 1946.
31. Senturia, B. H.: Penicillin Therapy in External Otitis. *The Annals*, 55:90 (Mar.), 1946.
32. Lempert, J. T.: Tympanosympathectomy. A surgical Technic for the Relief of Tinnitus Aurium. *Arch. Otolaryng.*, 43:199 (Mar.), 1946.
33. Atkinson, M.: Diagnosis and Treatment of Meniere's Syndrome. *Arch. Otolaryng.*, 37:40 (Jan.), 1943.
34. Atkinson, M.: Meniere's Syndrome. Result of Treatment with Nicotinic Acid in the Vasoconstrictor Group. *Arch. Otolaryng.*, 40:101 (Aug.), 1944.
35. Day, K. M.: Hydrops of Labyrinth (Meniere's Disease). *Laryngoscope*, 56:33 (Feb.), 1946.

Is There a Specialist in the House?

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The reader is fooled for a time into believing that a doctor committed the crime but it always turns out that the fellow was an imposter, not a doctor at all. It is not good literary form to make the doctor a villain.

At no time in the history of medicine has investigation of the doctor been so extensive. There are some who violate the literary form, who villify the doctor as a mercenary, uneducated leech, who cares more for the almighty dollar than for the welfare of a community. The "high cost of medical care" is a common phrase in Congress. Who is to blame?

On the one hand we see a political organization worrying about the common welfare and medical care for everyone; while the opposing force is organized medicine as represented by the American Medical Association. These two forces raise a great storm of confusion. One hears much of regimentation, organized medicine, the Murray-Wagner-Dingell Bill, of prepaid health insurance. There are pros and cons for state medicine, and group practice is offered as a solution by some. The public is vitally interested but confused.

The cloak of professional immunity has been lifted sufficiently so that one does not see a doctor as a villain in a story, or a hero, or a saint. One sees many different kinds of people under the cloak, no two alike, some interesting.

If one draws a circle on the map of the United States using the middle of Manhattan as the center of a twenty-five mile radius, one would enclose an area in which live over twenty-five million of the people of the United States. On a clear day one can stand on the observation point of Eagle Rock near Montclair, New Jersey, and see over most of this area where dwell nearly a quarter of the population of the United States.

Similar circles could be drawn about Chicago, Philadelphia, and San Francisco. The total number of people enclosed in these areas would comprise a large proportion of the population of the country.

That brings out the fact that the major portion of our people are urban. The rest live in rural areas.

Much criticism of the doctor has been leveled at the medico for his tendency to also select the city. There is no criticism of a university for establishing a medical school in a city. This is understood to be the correct thing to do, for the "poor we have with us always." The student can have good teaching in good free clinics which are available to the poor. Likewise, autopsy material and the cadaver for dissection are more available at the larger centers.

The student is therefore taught in a city where everything is promptly and cheaply available. The laboratory facilities are of the best. The student knows the meaning of blood sugar levels, of Hinton or Wasserman tests, of blood counts and of countless other laboratory matters. He does not try to develop the seat of the pants type of flying in medicine—he depends on instruments. The so-called "clinical hunch" is developed somewhat but there is less hunch when there are more laboratory figures, more measurements.

The student is taught each division of medicine or surgery by a specialist. Psychiatry or Dermatology is not left to a general practitioner or to an internist. Recently the American Medical Association approved a new board, coined a new name for the specialty, Physiatry —a physiatrist, a doctor of medicine who deals exclusively in treatment of diseases by physical means, such as diathermy, driving heat deep into the tissues by means of an ultra short-wave radio machine. Ultra violet light treatment or artificial sunburn would also fall in that department.

The other boards which accept applications from Medical doctors for approval and license are:

1. American Board of Pediatrics.
2. American Board of Psychiatry and Neurology.
3. American Board of Orthopedic Surgery.
4. American Board of Surgery.

5. American Board of Dermatology and Syphilology.
6. American Board of Radiology.
7. American Board of Urology.
8. American Board of Obstetrics and Gynecology.
9. American Board of Internal Medicine.
10. American Board of Pathology.
11. American Board of Ophthalmology.
12. American Board of Otolaryngology.
13. American Board of Anesthesiology.
14. American Board of Plastic Surgery.
15. American Board of Neurological Surgery.

The policy of the American Medical Association has been to encourage specialization by this system of licensure. Each board holds the members accountable for a certain degree of proficiency.

C. H. Browning in an address recently delivered in Glasgow, Scotland, stated that it is much more difficult to produce a competent general practitioner than a specialist. The army established a hospital system under the Consultants Division of the Surgeon General's Office. Medical officers were classified by numbers designating the type of work for which he was fitted. A ward surgeon had a number, a flight surgeon had a different number, an orthopedic surgeon still another—3153. To this number was added a letter—A for consultants and specialty chiefs, B for certification by a specialty board of the American Medical Association, C for incomplete training in a specialty, while D indicated simply minimal training and experience in a specialty.

The Navy had a similar system and with the recent establishment of a Veterans' Administration Consultants Division, the system is the same in all respects.

The American Medical Associations frequently moans at the dearth of specialists. Occasionally articles appear about the general practitioner, some pro—some con.

There is the usual discussion of the doctor-patient relationship which is considered so valuable. But the crux of the present difficulty in rural areas and in the city is that the American Medical Association actually is to blame for the extermination of the rare bird, the general practitioner.

Whatever may be the merits of any socialized medical bill, a rider should be attached to the bill providing that if and when state medicine becomes a fact, no doctor may be permitted to become a specialist until he has served five years as a practitioner. Perhaps this would solve the problem of the rural communities. After an internship the young doctor may take a residency in a specialty and become a specialist without having done general practice.

In spite of the drain on the supply of doctors during the war years by the Army, the Navy, and the United States Public Health Service, the doctors are now returning to civilian life. They are for the most part finding places in cities, they do not want to settle in the country towns because they are used to better facilities. The war sucked the small farmers into the war plant areas. It took country people with small scale ideas and values into the faster, more expensive whirl of the city. The doctors likewise are drawn to the city.

The American Medical Association is largely to blame for the dearth of doctors in rural areas because of specialization and the constant raising of standards of medical education has led to the narrowing of the educational possibilities for young men. Thousands are turned away from medical schools yearly, because there are not enough grade A medical schools to answer the need. There are few students who do obtain admission who are sure of survival. Many of the medical schools admit a large Freshman class with full intention of weeding out the unfit by the second year.

Maine had a medical school prior to 1921.

The campaign of the American Medical Association to eliminate class B or C medical schools resulted in closure of the schools that could not meet the standards. The schools in larger cities only could survive for these had teaching material available. Bowdoin Medical School was squeezed out of existence.

Vermont almost lost its medical school at the same time but chose to tell the American Medical Association where to go. As a result, the State of Vermont has been able to keep up its supply of general practitioners while the people in Maine see that no great numbers of new doctors are coming into the state, the old ones are dying off rapidly, and the present average age of the doctor in Maine is over fifty years!

During the war, with the young men in the service, the average age of the doctor in Maine was found to be sixty-one! With the return of the veterans the figure dropped.

The Maine State Medical Association, a branch of the American Medical Association is alarmed. Efforts are being made to resurrect the old medical school, for in a matter of a few years, the doctor-patient relationship may be only an academic interest. There are twelve states in the Union without medical schools. Of these only Florida and New Jersey exceed Maine in population.

Florida has no dearth of doctors because of its climate. Every general practitioner would like to migrate to escape the winters of the North.

New Jersey needs no medical school for New York has several and Philadelphia is just across from Trenton.

The pauper in New England can obtain medical care. The old town meeting form of government still works. The unfortunate victim of accident or illness will not stay a pauper if he can help it. He may "call on;" the town manager or the first selectman sends a doctor, guarantes the bill. When the man is able to pay again, he pays the town. While he is "on the town" he does not vote.

The trouble with the Murray-Wagner-Dingell Bill is that there is no social insurance that will cover a beachcomber—a pauper or the man who has no job, who pays no insurance or taxes. The bill has a Red tinge; is communist inspired.

The office of the general practitioner has become the sorting station for the specialist. People of today believe they have as much diagnostic ability as the general practitioner. So general has this concept become, that most people think over their troubles, decide which specialist should see his or her case. The general practitioner is by-passed.

A man knows in a general way about allergy. If he has asthma he goes to the allergist, bypassing the general practitioner, who would have been able to tell the patient that he is not suffering from allergy but from a heart condition. He has cardiac asthma. The tests for the allergen do not tell half as much as feeling the pulse! The outlook of so many of the specialists is so colored by specialty that a man or woman may go to six or seven different specialists before finding an answer. A single trip to a competent general practitioner would have saved him or her most of the expensive fees asked by the several specialists.

Suppose one has a backache. One by-passes the general practitioner, goes to see an orthopoedic specialist. Of course the orthopod takes X-rays and treats the patient from his standpoint. If the patient selected a kidney specialist because the pain was where he thought his kidneys were, more X-rays may be taken and more studies conducted, but from the natural bias of a urologist. If the patient is a man, the prostate comes under suspicion, if a woman, the uterus. The gastroenterologist suspects the bowel while the neuro-physciatrist thinks the whole matter a psychosomatic complaint, that is, a mind over body effect.

Many fruitless laboratory ventures and expenditures may result from a poorly directed investigation, yet the average man on the street thinks his ability to pick a specialist is as good as any.

Now we try to find reasons for the passing of the general practitioner. The A. M. A. holds that if he is a general practitioner he is not a surgeon, but a medical man because he is not approved by the specialty board for surgery. He is not approved by the specialty board for internists, so he is not an internist.

The hospitals are held in line by the American Medical Association, the American College of Surgeons. The American Medical Association classifies the hospitals. Unless certain standards are met the recognition of the hospital is withheld.

The general practitioner is therefore crowded out of most hospitals in the United States by the specialist. The general practitioner became an inferior being, destined to feed his surgical cases to the surgeon who jealously guards his position.

Fee splitting does figure but the matter is entirely beside the point and not worth further mentioning.

This relegates him to the position of pill peddler from his own office, referring his cases.

Yet the general practitioner is still to be found in the rural areas. He knows good practical psychology, he knows almost everybody by his first name. When there is a baby to be

delivered he is an obstetrician. When there is a formula to write for the baby he is a pediatrician and if there is a gastro-intestinal upset, the old medico doubles for internist, the urologist or the surgeon as the need may arise. He is a skin specialist. If there is something wrong on the skin, under the skin or somewhere inside the skin as a whole, he regards the skin and its contents as a whole person.

Many of the general practitioners found their way into the military service. There, they at first enjoyed the "just waiting." One only had to do a small amount of actual work. Emphasis was on preventative medicine.

One worked only a stated number of hours which was a relief after years of twenty-four hour duty and the ever present telephone.

Anytime after the first of the month he cashed his pay check. Counting everything he was well paid, better than when he worked twenty out of twenty-four hours. He bought at government prices at government stores.

There were free consultations among each other in the services. There was little, if any, professional jealousy. A slip went with a patient, a polite and useful comment by a specialist came back. There was no stealing of patients, no splitting of fees—in fact one worried not at all for the doctor did not have to ask for his two, or three, or five dollar fee.

The doctors who had stayed behind raised the prices on calls. Deliveries of babies were no longer done in the home, one had to go to a hospital and the fee rose one-third. But money was easier, people paid cash for calls, hospital insurance had become more universal because money was plentiful and the doctor could now be paid. But the returned general practitioner returned also to the professional jealousy which must be inherent in the present system. When he refers a patient to the larger center or a specialist, the patient is lost to him. The general practitioner gets an office fee, the specialist gets the big money without the twenty-four hour vigil kept by the party of the first part. It is almost impossible to get a word by letter about the patient from the specialist, he is too busy to be courteous in the matter.

State medicine seems possible and practical to some returned service doctors and it offers the freedom of asking for the fee.

The general practitioner is not represented in the councils of the American Medical Association. He has some small representations in the county medical societies. In states like Maine and Vermont, he has some influence in the State Medical Societies but the American Medical Association does not represent the opinion of the general practitioner. He is greatly outnumbered.

The veterans who are to be patients in hospitals of the Veterans' Administration are to be treated by specialists. There is a 25% increase in pay for one approved by the Specialty Boards of the American Medical Association, and the rank given to the specialists is higher than to non-specialists.

The number of veterans who have applied for hospital care is overwhelming. To hospitalize all these has proved to be impossible. The Veterans' Administration has been casting about for the answer in the civilian hospitals. An out-patient service like the old army and navy sick call has been set up. This was not sufficient so a plan to bring in the family doctor on a fee basis was proposed. A tentative fee schedule was set up.

This move was viewed with alarm by the American Medical Association. Was this an entering wedge toward State Medicine?

Meanwhile the veteran is waiting for an answer.

There is no place in the hospital set-up for a squadron or battalion surgeon such as the veteran may have had in the army. The battalion surgeon was just a general practitioner. He never was permitted to give definitive treatment nor did he do surgery. He simply sorted out cases for the specialists who took the care and responsibility away from the battalion surgeon. The general practitioner on a fee basis would fit the same position.

Now specialization is overdone. There is no great mystery to the art of medicine that requires so much classification as has been accomplished.

There is an old joke about the specialist. "He knows more about that which about which we know little or nothing." There is more truth than poetry in the quip.

Take allergy as an example. Doctors do not know the cause of allergy or why one family will have several individuals with sensitivity.

Continued on page 129

Benadryl Hydrochloride and Its Possible Application in the Management of Peptic Ulcers

(WITH A CASE REPORT)

George Geyerhahn, M. D., Portland, Maine

Benadryl is said to be the most powerful histamine antagonist. Antiacids, atropine preparations, and diets, etc., have been used in the treatment of peptic ulcers. Also a preparation "Larostidine," a histadine preparation, was used; it was claimed to be a histamine antagonist. For some reason this drug was not too popular among the medical profession. The entire medical management has been so unsatisfactory in that some surgeons have advocated surgery in any proved peptic ulcer. Since histamine stimulates secretogogue action of the glandular cells in the stomach, the logical approach appears to be to decrease or counteract histamine in the management of peptic ulcers. McGavah, T. H. Gliss, and H. Boyd* found among sixteen normal subjects increased gastric acidity, due to Benadryl, in twelve, and gastric secretion reduced in six cases.

Although Benadryl has been used principally in the control of histamine in allergic conditions it has occurred to the writer that it might also be of similar use in controlling excess acid production in peptic ulcer. Consequently, this idea was applied in several cases, with one to be reported here, because this one was the only one proved by X-ray, the others were only diagnosed clinically. However, it shall be said here that all cases responded very well to Benadryl.

Case Report

A 34-year-old white female gave a past history of peptic ulcers. The remaining history and review of systems was irrevelant except for gastro-intestinal system—pain in abdomen occurred especially in epigastric region and was aggravated by fried and spiced foods. Pain was noted between meals, but no melena or bloody stools. Occasionally nausea, anorexia, and emesis was experienced.

Physical examination: A well developed, undernourished, pale, over middle-aged appearing white female not in acute pain had temperature, 98.2; pulse, 80; respirations, 20; blood pressure 140/70. Head, eyes, ears, nose, and throat were negative. Neck: Thyroid was palpated, but no glands felt. Chest: Heart and lungs were negative. Abdomen was tender throughout the entire right side and there was also some rigidity present. There were no masses or enlarged organs felt. Vaginal examination: Left ovary was felt to be the size of a walnut. Extremities were negative.

Course

X-ray examination showed that there was considerable gas and fecal material in the colon which obscured the kidney outlines and any shadows that might be present. There were a number of pheboliths in the pelvis, otherwise, there was nothing remarkable. Gastro-intestinal examination showed the esophagus to be normal. The stomach was low in position, the outline regular, peristalsis normal, no defects. The duodenum showed a marked and constant irregularity with a niche in the central portion of it over which there was a definite acute tenderness. At the end of six hours there was no residue in the stomach. The head of the barium column was in the transverse colon. Impression was duodenal ulcer, active, non-obstructing.

Laboratory work showed hemoglobin 85%; RBC-4,050,000; WBC-9,100; MCH-30; platelets normal. Urine was slightly cloudy, yellow, acid, S. G. 1.015; sugar-orange (glucose given previously), acetone 3 plus, RBC-occasional, WBC-5-6, epithelium plus, negative for albumin, diacetic acid, bile, casts, crystals, and bacteria. Feces examination was negative for occult blood.

After a week on Sippy diet patient was given Benadryl 50 mg. t. i. d., and a diet ad libidum. (The Sippy diet was not well tolerated.) The

* Gastroenterology, 6:439, 1946.

pain and nausea disappeared immediately and she was able to eat all types of food without discomfort, the appetite improved, and she gained ten pounds in the first month.

Summary

One case of X-ray proved peptic ulcer was treated with Benadryl hydrochloride. The patient was pain and symptom-free within a few days and gained ten pounds within a month. She gradually decreased her medication and finally discontinued it and has been well ever since. Several other cases with typically clinical signs of peptic ulcers were treated also with Benadryl with identically good results.

Conclusion

There is no report on the use of Benadryl hydrochloride in the management of peptic ulcers in the literature. It was tried here in one proved case of peptic ulcer with good results, and others not proved by X-ray with similar results. It is suggested that this drug should be used on a larger clinical scale to evaluate better the benefits in the management of peptic ulcers.

Is There a Specialist in the House? — Continued from page 127

Psychiatry is in its infancy. Much of the complicated jargon of the psychiatrist is not understood by the rest of the medical profession, let alone a lay person. Yet he does not actually know the cause of most mental illnesses.

The internist knows nothing of the cause of migraine headaches, of hypertension or cardiovascular disease or diabetes. The surgeon does not know why people develop troubles with gall bladders or cancers which require removal, or does he know what makes a person suddenly develop a thyroid condition. This small list of diseases about which we know little or nothing contains the killers.

These specialists are not good researchers, for aside from the fact that they choose their own hours in which to see patients, or they are too busy, they have each their own natural bias for their specialty. Therefore, an ex-general practitioner makes a better overall investigator. Obviously, a non-doctor is handicapped.

The general practitioner who read a little of all kinds of specialties sees a glimmer of truth in the whole picture. He suspects that the trouble of the individual who has allergy, a mental illness, gall bladder or migraine headache, may be dietary. To another doctor he might say that it was a matter of improper handling by the body of critical water balances —but he is just as close as any one to the truth.

There is too much hocus-pocus about specialists even if the Army, the Navy, the Public Health Service and the Veterans' Administration have been built up around the concept as laid down by the American Medical Association.

The average age of the population is increasing, the number of cases of tuberculosis in the aged is showing a commensurate rise. The disease in the elderly may be even more prevalent than mortality statistics suggest, since a significant number of deaths are not accurately reported. J. D. Wassersug, M. D., *N. E. Jour. of Med.*, Aug. 15, 1946

A factor which has unquestionably retarded the control of tuberculosis has been an unwillingness on the part of the public and the medical profession to look upon tuberculosis as a communicable disease. The possibilities of prevention have been generally obscured by the stigma that has dogged the disease through the centuries. Henry D. Chadwick, M. D., and Alton S. Pope, M. D. *The Modern Attack on Tuberculosis,* The Commonwealth Fund, Revised, 1946.

Health, like freedom and wealth, cannot be given, but must be earned. Edward J. Stieglitz, M. D., *A Future for Preventive Medicine,* The Commonwealth Fund, 1945.

Clinico-Pathological Exercise

Gynecological Case Presented at the Eastern Maine General Hospital, Bangor

Edited by Joseph E. Porter, M. D., Portland

Patient: White, female, age 44, housewife. Married for 15 years. No pregnancies, although children were desired and two were adopted.

Chief Complaint: Profuse vaginal bleeding.

Past History: Although patient denied any serious illnesses, there is a history of arrested tuberculosis in childhood. Otherwise, except for the usual childhood diseases, including measles, mumps, and chickenpox, general health had been fairly good. No previous operations. Review of her system history was essentially negative. She was subject to upper respiratory infections during the winter months. She had frequent attacks of what was termed "indigestion." These consisted chiefly of the accumulation of considerable gas after eating, and not precipitated by any particular foods.

Present Illness: About 8 months ago patient became very nervous and began to have hot flashes. She was unable to sleep and noticed that she became very tired at her work. She was seen by a physician who made a diagnosis of menopausal syndrome and treated her weekly for 4 months with injections of estrogen. Six months ago her menstrual periods ceased for two months, and for the past 4 months she has been flowing almost constantly, so that she had to spend a good part of every day in bed. She noticed that she felt weak and had no ambition to do her housework.

Physical Examination: A well-developed, pale, middle-aged female who appeared somewhat nervous. Mucous membranes were pale; nose and throat negative. Heart not enlarged; soft systolic murmur at the base. Lungs clear and resonant; no rales heard. Abdominal examination negative except for slight tenderness in both lower quadrants. Pelvic examination revealed a normal cervix; uterus felt slightly enlarged, especially on the right; adnexae were normal.

Laboratory: Urine negative. Hemoglobin 10 gms.; RBC. 3,500,000; WBC. 7,500.

Course: In view of the prolonged bleeding, it was decided that laparotomy should be performed. Accordingly, the abdomen was opened through a midline incision. Both tubes and ovaries appeared essentially normal. Uterus was slightly enlarged and the wall felt firmer than normal. A hysterectomy was performed. Abdominal examination otherwise showed no abnormalities.

Postoperative: Fever to 103° F. for two days. Penicillin was given and the temperature returned to normal. On the 5th day she was allowed out of bed. Temperature and pulse remained normal. The wound healed per primum, and the sutures were removed on the 7th day.

On the 9th day, while she was sitting in bed and talking, suddenly everything went black. She had no pain whatsoever, but she said to her nurse that she felt as though she was going to faint, at which point she suddenly lost consciousness. Her pulse became rapid and her blood pressure fell to 80/60. With supportive therapy she recovered consciousness in about fifteen minutes, but had partially lost the use of her right arm. She also had a slight right facial weakness. When she regained consciousness she could answer questions, but seemed confused. Four hours later, she suddenly had a generalized convulsion, and lapsed into unconsciousness. Reflexes were all hyperactive. There was a bilateral Babinski. She steadily went down hill and died 24 hours later. During the period of unconsciousness she had several generalized convulsions.

A spinal tap showed increased pressure. The fluid was clear, with normal cell count.

Discussion

Dr. Ralph C. Powell: Marriage without pregnancy may be significant and suggest some disease of the genital tract which prevented pregnancy — possibly old pelvic inflammatory disease, tuberculosis, or some dysfunction of the pituitary or ovary. Profuse vaginal bleeding in a woman of 44 years may be due to one or more of many causes. To be considered would be:

Vulva: Carcinoma, trauma, ruptured varix, lymphogranulomatous lesions, gumma, hemengioma, tuberculous ulcer, atrophic vulvitis, necrosing fibroma, ruptured hyman, prolapse of urethra, ruptured Bartholin cyst, and endometriosis.

Vagina: Carcinoma, ruptured varix, trauma and lacerations, ruptured cyst of Gärtner's duct, tuberculosis, granulomatous lesions, atrophic vaginitis, endometriosis, necrotic fibroid, gumma, erosion due to pessary, post-irradiation slough.

Cervix: Carcinoma, polyp, endometriosis, erosions and ulcers of chronic cervicitis, tuberculous ulcerations, instrumentation, gumma, granulomatous lesions, post-cauterization slough.

Fundus of Uterus: Carcinoma, sarcoma, menstruation, leiomyoma, tuberculosis, adenomyosis, trauma, retrodisplacements, atrophic endometritis, endometrial hyperplasia (functional bleeding), post-irradiation slough, withdrawal of estrogens.

Fallopian tubes: Carcinoma, endometriosis, pelvic inflammatory disease.

Ovaries: Follicular cysts (not common cause); endometriosis; granulosa cell tumor, thecoma, luteoma, any large cyst or tumor of ovary causing uterine bleeding by back pressure, and hence congestion, tuberculosis, abscesses, ovulation.

Theoretically one should think of all these things as causes of vaginal bleeding in a nonpregnant woman. Also, all of the hemorrhagic diseases and leukemia could cause bleeding.

There is no menstrual history up to 6 months ago. We do not know whether there had been previous irregular or profuse bleeding. We must think of the possible effects of estrogens and the sudden cessation of all menstruation. The nervousness, hot flashes, and weakness could occur as menopausal symptoms, but indicate no specific cause for the bleeding.

There is a history of arrested tuberculosis in childhood and the possibility of a tuberculous lesion in the genital tract has to be kept in mind. The attacks of "indigestion" are not specific. Gastritis and peptic ulcer usually give a history of vomiting and pain, and certain foods are usually blamed.

The soft systolic murmur at the base of the heart could be functional and could go with anemia, although the blood findings do not indicate an especially severe anemia.

The abdominal examination was negative except for slight tenderness in both lower quadrants; the pelvic examination was also negative, except that the uterus felt slightly enlarged, especially on the right. With a history of being married for 15 years with no pregnancies, there is the possibility of an old chronic pelvic inflammatory condition, but this is not substantiated by the history or the examination. The possibility of a fibroid of the uterus cannot be overlooked. I think we can rule out tumors of the ovaries, which in their effects on the ovaries themselves and the secretion of hormones might cause a disturbance of the ovaries.

The blood examination does not indicate that this woman was "bled out," and it does not seem likely that she could have had the profuse bleeding mentioned in the chief complaint. Information as to the blood pressure would help.

Operation ruled out pelvic inflammatory disease, and gross tumor of ovaries. There was no gross enlargement of the uterus, and probably no carcinoma. There could be a superficial tumor or ulceration of the uterus which could cause the bleeding. I would like to know the pathological findings on the uterus and ovaries.

Dr. R. C. Wadsworth: Do you think now is the best time? Suppose we give the gross findings in the uterus. I might confess that we had the information only through the time of operation when we decided to use this case for this conference. The patient was alive at that time. What happened after that was unex-

pected. Grossly the uterus was slightly enlarged and sections revealed no tumors. The surface of the endometrium was somewhat granular and red.

Dr. Powell: No gross ulcerations?

Dr. Wadsworth: The surface was definitely granular, which one does not see in a normal uterus.

Dr. Powell: Ulcer?

Dr. Wadsworth: No discernable ulcerations. There were areas of diffuse red discoloration partly about the region of red granularity.

Dr. Powell: I wonder if she was actually bleeding when they took her up for operation. Had it let up or stopped?

Dr. Wadsworth: Bleeding continued to day of operation.

Dr. Powell: From the history one would have to stop and consider some of the causes of uterine bleeding mentioned before. Of course, carcinoma is not ruled out yet. There is no definite gross picture. These granular findings in the endometrium make me think of tuberculosis, since she had had it in childhood. Tuberculosis of the tubes and ovaries is more common than tuberculosis of the uterus itself. I cannot think of any other causes of granular endometrium except possibly X-ray or radium treatment, and she has no history of having had any treatment. I think at this point the diagnosis would probably depend upon microscopic study of the uterus.

Dr. Wadsworth: Before we go on to the postoperative course, let us have an expression of opinion, and then we will give the diagnosis.

Dr. Powell: I would consider then carcinoma. It cannot be ruled out. Tuberculosis in a woman of this age would also have to be considered. Some sort of endometrial hyperplasia with functional bleeding is another consideration.

Dr. Roy Crosby: What are you putting first?

Dr. Powell: Tuberculosis; second, carcinoma.

Dr. Wadsworth: I think we might tell then what was found. The histology of the uterus showed two conditions present: (1) An adenomyosis with glands dipping down quite deeply into the myometrium; and (2) both on the superficial endometrium and down in the glands which were in the myometrium there was tuberculosis.

Dr. Powell: Do you not usually find tuberculosis more commonly in the tubes?

Dr. Wadsworth: Yes. Possibly the infection extends through the tubes into the uterus. There have been some reports of finding tubercle bacilli in the lumina of the tubes, with no actual tubercle formation.

Dr. Powell's Diagnosis

1. Tuberculosis.
2. Carcinoma.

Dr. Richard Wadsworth's Diagnosis

1. Tuberculous endometritis.
2. Adenomyosis.

Postoperative:

Dr. Powell: Of course, one of the first things you think of is a sudden severe hemorrhage somewhere. There is the possibility of hemorrhage at the site of operation on the 9th day postoperatively. The regaining of consciousness with signs of facial weakness and loss of motion in right arm may be due to neurological conditions — cerebral hemorrhage, emotional upsets and trauma. Also to be considered are rupture of an aneurysm, hemorrhage into a tumor, hyperglycemic attack, shock itself, and embolism.

Ruptured aneurysm can be ruled out. Hemorrhage into a tumor cannot be ruled out at this point. Hypoglycemia probably can be ruled out. There is no history of taking insulin. Embolism cannot be ruled out — blood clot or, theoretically, even a fat embolus. The bilateral Babinski is not consistent with weakness of right side of face or arm. Another condition could be intracerebral hemorrhage. Uremia could not give this picture. Her urine is negative. Non-protein nitrogen was not determined, but I think uremia can be ruled out.

Convulsions can be caused by many factors: Epilepsy—history; brain tumor—no neurologic signs or symptoms; cerebral scar, post-traumatic—no history; hemorrhage—no red cells in spinal fluid; anoxia; acute infection such as meningitis—did not have fever, and spinal fluid was essentially negative.

Dr. Wadsworth: I might add that the spinal fluid showed total proteins 97 mg./100 cc., and the cell count showed 4 leukocytes and 2 red cells.

Dr. Powell: I am in doubt as to the diagnosis on the cerebral findings. With a history of tuberculosis, tuberculoma has to be considered, but if tuberculosis was present there would probably be disseminated signs as well as local signs. I would say tuberculoma with the possibility of tuberculous meningitis, but the spinal fluid is negative. At this point I would say tuberculosis and embolism.

Dr. Crosby: How would the embolism get there?

Dr. Powell: I do not know. It would have to go through the heart and lungs unless she had a patent ductus. I do not know the diagnosis.

Dr. Wadsworth: Does anyone else have anything to say?

Dr. Crosby: As Dr. Powell says, the sudden onset and loss of consciousness could be due to cerebral hemorrhage of some sort. Blood pressure and loss of use of right arm are consistent. Bilateral Babinski can occur in acute stages of cerebral hemorrhage. Usually there is not increased spinal fluid pressure. The best bet in this case is cerebral hemorrhage in the region of the left motor cortex or its connections with the left internal capsule.

Dr. Charles E. Gilpatrick: Her red count was down quite a bit. When she had her operation she lost quite a bit of blood.

Dr. Powell: There would have been a change in the spinal fluid unless intracerebral.

Dr. Gilpatrick: Intracerebral, that is what I mean.

Dr. Wadsworth: The chances of a hemorrhage into a tuberculoma are extremely rare.

Dr. Crosby: Hemorrhage into a tumor is rarely found pathologically. If you go back over the history, you find no episode to account for a hemorrhage.

Dr. Wadsworth: We did not have an autopsy in this case, and the diagnosis in the second episode is really anybody's guess. It tends more towards cerebral hemorrhage than any other one condition. There are a few things that do not quite fit this diagnosis, and probably should be mentioned. The two things that one is very apt to get with increased pressure are headache and vomiting, and this patient had neither. Although not attributed to the hemorrhage itself, we know from the spinal tap that there was increased intracranial pressure. What she probably had was intracerebral hemorrhage rather than thrombosis or embolism. I am inclined to think that the bilateral Babinski occurs more frequently with intracerebral hemorrhage.

Dr. Crosby: We do not know how much the pressure was increased.

Dr. Wadsworth: I was just speaking in general terms. The hemorrhage must have been fairly extensive because of the outcome. If it had been a small hemorrhage, she would probably have lived. The involvement of her right arm and the weakness of the right side of the face were rather minimal for what the rest of the picture shows. The fact that she recovered consciousness and remained conscious for a while is a little bit against cerebral hemorrhage, but does not rule it out, because her consciousness did not last very long.

The main point in presenting this case was to bring out the fact that tuberculosis of the endometrium does occur, and it is one cause of uterine bleeding which can usually be discovered by curettage. Once the diagnosis has been made in the absence of active pulmonary tuberculosis, a hysterectomy or panhysterectomy is indicated, or at least there should be removal of the part of the genital tract that has become infected. Unfortunately in this case the tubes were not removed. We were just told that superficially they appeared unaltered. If a diagnosis of tuberculosis has been made, patients do very well clinically after the uterus and tubes have been removed.

Dr. Leon S. Lippincott: Wouldn't a total hysterectomy rather than just removal of the fundus be better in a case like this?

Dr. Wadsworth: Yes, the cervix might be involved. I think in 2% of the cases the cervix is involved.

The President's Page

There seems to be a genuine scarcity of Nurses. This has become so great in some Communities, that entire wings of Hospitals have had to be closed.

We know that some of the Nurses have married, and given up Nursing. However, we believe that comparatively few have done so on this account. In fact, in our small Hospital, the large majority of the Nurses are married.

But the number of girls studying for this profession, is far less than ever before. Why is this true?

We believe that if the Nurse were offered a decent minimal salary, she would gladly leave any occupation she may have gone into because of greater remuneration, and so go back to Nursing.

It would seem to us that the scarcity of Nurses is but a part of the whole economic dilemma which the whole country finds itself in.

It is deplorable to see nurses, whom we have always considered a very material part of the Medical profession, feeling it necessary to join the A. F. of L. or the C. I. O. as they are doing in some parts of the U. S. A.

"Let's give them a break." Speak of them as Professional Women and help them to get as high a minimal wage as a teacher gets.

Even a Charwoman is paid in most instances from 75 cents to $1.00 per hour, which figures up to $42.00 per week. How many Nurses receive that wage?

In my opinion, that is one more problem that we are going to have to face and settle in the not too distant future.

John O. Piper, M. D.,
President, Maine Medical Association.

Editorial

The Ninety-third Annual Session Program

The program for the Ninety-third Annual Session, to be held at the Marshall House, York Harbor, June 22nd, 23rd, and 24th, is published elsewhere in this issue of the JOURNAL, and a copy sent to each member of the Association.

Much time and effort has been spent by Dr. Dexter E. Elsemore, Chairman of the Scientific Committee, and members of his committee, in arranging a program that will have something of interest to every member of the Association. I believe that they have been remarkably successful in their endeavor.

Mr. Edward P. Stegen, Associate Administrator of the National Physicians' Committee, will speak Sunday evening at 8.30 P. M. Dr. Stegen's subject will be "American Medicine in Transition."

Other Out-of-State speakers will include Drs. Richard B. Cattell, E. B. Astwood, Richard H. Sweet, Abraham Colmes, and Edward O'Keefe, all of Boston, and Dr. G. G. Duncan of Philadelphia.

The Conferences from 9.30 A. M. to 12.00 noon, on Monday and Tuesday, will be conducted by members of the Association well known to you all for their ability in the subject to be discussed.

Speakers Monday evening will be Winthrop Adams, M. D., who will speak on "Medical and Hospital Care of Veterans Under Veterans' Administration," and Miss Esther Lipton of the State of Maine Department of Education.

The Maine Medico-Legal Society will hold its annual meeting on Tuesday, June 24th, at 9.00 A. M. This meeting, which has become a feature of the annual session, will have as speakers, A. Warren Stearns of the Department of Sociology, Tufts College, and LeMoyne Snyder, M. D., Medico-Legal Director, Michigan State Police.

Professor Julius S. Bixler, of Colby College, Waterville, will be guest speaker at the annual dinner, Tuesday evening, June 24th, at 8.00 P. M. Presentation of Fifty-Year Service Medals to nine members of the Association, who have rounded out fifty years in the practice of medicine, will also be a feature of the annual dinner program.

Your President, Dr. John O. Piper, of Waterville, will present his Presidential Address at the Scientific Session, Monday afternoon.

The House of Delegates will meet on Sunday, June 22nd, at 3.00 P. M., and Monday, June 23rd, at 5.30 P. M. The Order of Business for the Sunday meeting will include the annual report of the Council Chairman, Dr. Forrest B. Ames, of Bangor. Dr. Ames will also present, for action by the House, the Budget for 1947-1948 as recommended by the Council. Election of Councilors for the Third and Fourth Districts will be on the Agenda for the Second Meeting of the House on Monday.

Election of the President-elect will take place at 5.00 P. M., Monday, immediately following the Scientific Session. Be there to cast your vote.

Introduction of visiting Delegates will take place at the Scientific Session, Monday, June 23rd, at 2.00 P. M. These delegates include Dr. Stanley B. Weld, from Connecticut; Drs. Harold G. Giddings, and Kenneth Maclachlan, from Massachusetts; and Dr. Frank Farmer, from Vermont.

The largest Commercial Exhibit in the history of the Association is signed up for the meeting. Make a visit to these exhibiting companies a part of your program while at York Harbor.

If you have not made your reservations—do so today. The time is limited—the rooms becoming scarce.

Executive Secretary's Report on Legislative Matters

As reported previously in the JOURNAL, your Association sponsored two measures in the last Legislature.

The medical college sought to be established as a part of the University of Maine required an initial appropriation of one million dollars. Funds were not available and the best that could be done at the time was to salvage an interim committee with a small appropriation.

The enabling act for voluntary prepaid medical care was defeated by concerted opposition. The plan as drawn would have enabled doctors of medicine to form a corporation for the purpose of offering this type of insurance to the public. The Committee for the Maine Medical Association had no objection to any other group practicing the healing art, obtaining their own enabling act and forming their own plan. It soon became evident in argument that the other groups did not feel able to sponsor and service their own plan, and, therefore, insisted that the present enabling legislation now granted to Associated Hospital Service was proper and sufficient. That enabling legislation permits a voluntary prepaid medical care plan but requires inclusion of all types of practice.

Although both pieces of legislation were defeated, the effect of this effort in the Legislature was definitely beneficial to the Maine Medical Association. The medical school would have benefitted the people of the State mainly in two ways; first, it would have trained doctors, many of whom would have stayed in Maine where they are needed; second, it would have offered the opportunity for refresher courses to physicians already in practice, thereby tending to raise the standards of excellence in practice.

The prepaid medical care plan would have offered the opportunity to middle income people to budget against catastrophic illness. Many such people have faced terrific bills for hospital and surgical services and have had to work and scrimp for years to pay them.

Many members of the Legislature are aware that the legislative program of this Association was sponsored and urged, not for the benefit of the doctors, who obtained no direct benefit from it, but instead for the benefit of the public and for the promotion of better medical service in Maine. Such a progressive and unselfish program has, I believe, won many friends for the doctors in this Legislature.

W. MAYO PAYSON,
Executive Secretary.

"Call On Some Doctors, Son . . ."

"Call on some doctors, son." That used to be the advise of old-time bucket-shop operators when instructing greenhorns how to sell stocks.

It *is* sound advice. Doctors, too often, are good prospects for blue-sky investments. When it comes to slick trading in securities, they haven't the time to investigate. They're scientists, analysts of human ailments, artists of the operating room, travellers in the night, worriers, dreamers, thinkers and curers. But not financiers.

Diagnose an illness? Sure. But when a thousand dollars could be made or lost on a one-point change in Giltedge, Preferred, they're busy; a child's appendix has ruptured.

Buy the best X-ray machine at the right price? Probably. But skillfully manipulate industrial investments to put their children through college? Or to take care of the family when the old ears are not so sharply attuned to the stethoscope, hands not so sure on the scalpel? Not very often.

A doctor is a busy man and a hopeful one — hopeful that the fees will take care of the future. True, some doctors are wealthy, or near it. To most, wealth is just something someone else enjoys. But many doctors, lulled by the crowded waiting rooms which went hand-in-hand with the war-born doctor shortage, figure they'll be pretty well set for retirement, the way fees are piling up.

Yes, the doctor needs a "bullet-proof" investment, and the United States has provided it in Savings Bonds. We all know that, but just to make it available isn't enough.

Most doctors need something more. In business matters they need a string tied around a finger. The Government is offering this to them in the new Bond-a-Month Plan. Your bank ties the string, gives it a yank every month. And all the doctor has to do is leave it there. Wilson Mizner said: "The gent who wakes up and finds himself a success hasn't been asleep." As to planning his future, once the doctor has invested in Bond-a-Month, he *can* give all his attention to his important work.

Before getting down to what the Bond-a-Month Plan can do for the non-salaried doctor, let's take a look at some of the facts in the case of the average practitioner. He's busy, more of late than ever before. His routine is hospital calls, perhaps an operation or two, office hours, house calls, office records, telephoning, more calls after dinner. Every so often a baby fails to realize the doctor has a schedule, or someone breaks a leg, or gets measles. Even the specialists work no 9-to-5 day.

The U. S. Department of Commerce has made studies of doctors' incomes, based on reports of a sample of the 139,000 men and women in private practice in 1940. The studies show that the income rises slowly to a maximum in the early 50's and then starts dropping. From 35 to 54 is the real money-making period.

At 35, most doctors have begun to pay off their starting-in-business debts, have built up a small neighborhood practice and are becoming known. Their practice grows with ability. By the time they are 54, other doctors, young and vigorous, have come in with new methods, machines, theories. They make inroads into the established practice of the veteran. The older man no longer so willingly drives out into the country on sick calls. Office hours are shaved a little at the start and the end of the day. There are fewer operations.

And somehow, without the doctor's really knowing why, the bank balance doesn't hold up the way it used to.

To come as close as we can to keeping the horse in front of the cart, let's see what Bond-a-Month will do and then explain why this is the solution to the doctor's problem of saving for future security.

Bond-a-Month opens systematic saving through Government bonds to anyone with in-

Continued on page 146

COUNTY SOCIETIES

Androscoggin
President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, Edward A. Greco, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
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Secretary, Kenneth A. LaTourette, M. D., Farmington

Hancock
President, Raymond E. Weymouth, M. D., Bar Harbor
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Frank B. Bull, M. D., Gardiner
Secretary, Arch H. Morrell, M. D., Augusta

Knox
President, Wesley N. Wasgatt, M. D., Rockland
Secretary, Freeman F. Brown, Jr., M. D., Rockland

Lincoln-Sagadahoc
President, Stanley R. Lenfest, M. D., Waldoboro
Secretary, John F. Dougherty, M. D., Bath

Oxford
President, Walter G. Dixon, M. D., Norway
Secretary, Dexter E. Elsemore, M. D., Dixfield

Penobscot
President, Edward L. Herlihy, M. D., Bangor
Secretary, John E. Smith, M. D., Bangor

Piscataquis
President, John B. Valentine, M. D., Dover-Foxcroft
Secretary, Norman H. Nickerson, M. D., Greenville

Somerset
President, Richard P. Laney, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Seth H. Read, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

Aroostook

At the Annual Meeting of the Aroostook County Medical Society held in The Aroostook Room of The Northland Hotel in Houlton, Thursday, May 29th, Dr. Gerald Donahue, Presque Isle, was elected as President.

After opening the meeting, Dr. P. L. B. Ebbett, the retiring President, gave a fine tribute to the late Dr. Frank H. Jackson, of Houlton, who was one of the organizers of the Society and its first Secretary.

Of the several Committee Reports, the report of the Committee to Study the Nursing Shortage in Aroostook County, came up for the most discussion, since this has become a very vital problem to the maintenance of proper health standards in our rural communities and hospitals.

This Committee proposed a Plan for organizing and maintaining a Group Training Program for Vocational Nurses among the various small hospitals of Aroostook to supply the needs of the County for Assistant Nurses to give necessary bed-side care to patients. It was pointed out by this Committee Report that but one training school for graduate nurses was now in existence in the whole County and that this one school was far too small to anywhere near supply the needs for nurses in this area.

The Society went on record to have this committee continue its investigations and authorized it to proceed to establish the plan as recommended by the Committee, acting in conjunction with the State Nurses' Association, the State Hospital Association and the Boards of the various hospitals in the County. This Committee is composed of Dr. Clyde I. Swett, Island Falls, Chairman; Dr. Storer Boone, Presque Isle; and Dr. Herrick C. Kimball, Fort Fairfield.

Dr. John B. Madigan, who recently located in Houlton, was elected to membership and extended a hearty welcome by the members present.

The Committee on Revision of Fees reported the new fee schedule which will go into effect in the County immediately. This revision was greatly needed since the rates charged for services have not been changed since 1937 even though costs of practice have risen greatly since that time. This schedule will be particularly helpful to the younger men who have just returned from the Armed Forces to start their practices.

The following officers were elected for 1947:

President, Gerald H. Donahue, M. D., Presque Isle; Vice President, Rosario A. Page, M. D., Caribou; Secretary-Treasurer, Clyde I. Swett, M. D., Island Falls; Delegates, Drs. P. L. B. Ebbett, Houlton; and C. I. Swett, Island Falls.

Following the business meeting, Dr. Forrest B. Ames, Bangor, Councilor for the Sixth District, gave an interesting talk on "The Relationship of the County Medical Societies to the Maine Medical Association."

This was followed by remarks from Mr. W. Mayo Payson, Executive Secretary of the Maine Medical Association, in which he explained in some detail the duties of an Executive Secretary as applied to the local Society.

The medical paper of the evening was given by Dr. Bernard Gagnon of Houlton. He chose for his subject, "The Rh Factor in Pregnancy and its Practical Application." This talk was particularly timely since the recent publicity given to the Rh factor in prenatal care.

CLYDE I. SWETT, M. D.,
Secretary.

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Friday evening, May 16th, at 6.30 P. M.

It was voted to see if arrangements could be made with the Washington County Medical Society for a joint meeting in September.

Harry Kopfmann, M. D., of Deer Isle, was chosen to be an additional member of the liaison committee between the County Society and the proposed Eastern Memorial Hospital trustees.

James M. Parker, M. D., of Portland, presented a paper on "Biliary Diseases," which was followed by a general discussion.

J. H. CROWE, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at Ralph Stuart's camp, at Whetstone Pond, on May 15, 1947, at 3.00 P. M.

Francis W. Bradbury, M. D., of Dover-Foxcroft, and Linus J. Stitham, M. D., of Dover-Foxcroft, were elected to membership by transfer from the Penobscot County Association and the Androscoggin County Association, respectively.

It was voted that a special meeting be held this summer at Moosehead Lake, and that the Penobscot, Aroostook, Somerset, and Kennebec County Associations be invited to attend.

Mr. W. Mayo Pason, Executive Secretary of the Maine Medical Association, and Forrest B. Ames, M. D., of Bangor, Councilor for the Sixth District, were present and spoke on matters to come before the Maine Medical Association at the annual meeting in June.

At about 6.00 P. M., the meeting was adjourned to Dr. George C. Howard's camp where Mrs. Dore, Mrs. Stuart, and Mrs. Howard served a most delicious supper. Our Association congratulates our Guilford brothers on choosing ladies who are such excellent cooks and charming hostesses for wives.

N. H. NICKERSON, M. D.,
Secretary.

Necrology

Frank H. Jackson, M. D., 1877-1947

Dr. Frank H. Jackson, oldest Medical Examiner in Maine in years of service and a practicing physician and surgeon in Houlton for more than 40 years, died suddenly at his home on Military Street, May 16, 1947. He was 70 years of age.

Dr. Frank Hussey Jackson was born in Hallowell, September 10, 1877, the son of Ella H. (Owen) and Frank H. Jackson of Jefferson. His family moved to Providence, R. I., when he was one year of age and he attended the public schools of that city before entering Brown University. Following his graduation, he attended Columbia University, College of Physicians and Surgeons from which he was graduated in 1901. He interned in New York City.

He began the active practice of his profession in Providence and, early in his career, became a member of the New England Surgical and the New England Obstetrical-Gynocological Societies. He came to Houlton in 1905 and, in the intervening years, his steadfast devotion to his profession earned for him the respect and esteem of his fellows in Northern Maine and throughout the state.

He was particularly proud of his long record as Aroostook County Medical Examiner, having been appointed to that position when it was first created in 1909, by the late Gov. Bert M. Fernald and was successively reappointed by every subsequent chief executive. He was active in this position at the time of his death.

He also had the distinction of serving as an examining physician for the local draft board during both World War One and World War Two and, during the latter conflict, also acted as medical director of civilian defense.

Long an active member of the Maine Medical Association, he served that organization for several years as editor-in-chief of its JOURNAL. He was also a member of the American Medical Association, a fellow of the American College of Surgeons and a member of the Aroostook County Medical Association. Throughout his life, he remained a keen student of the advancement of both medicine and surgery.

He was a member of the staff of the Aroostook Hospital here from the time of its organization and had only recently retired as its president.

The tributes from the fellow members of his profession which followed his death testify to his standing among them and measure to considerable degree his prominence in his field, both in this county and throughout the state.

He was a 32nd degree Mason and a member of Anah Temple Shrine. Always a lover of the outdoors, he was a member of the Houlton Fish and Game Club and a regular attendant at its meetings.

He was married in 1903, to the former Lillian A. Spofford of Toronto, Canada, who survives. He is also survived by his mother and by one daughter, Mrs. John Adkins of Boston.

In Memoriam

Members Deceased since May 31, 1946

Elliott, William T.,	Berwick
Gregory, George A.,	Boothbay Harbor
Jackson, Frank H.,	Houlton
Love, George R.,	Saco
Marcotte, John B.,	Lewiston
Moulton, Charles A.,	Hartland
Parcher, Arthur H.,	Ellsworth
Small, Morton M.,	Waterville
Wakefield, Ralph W.,	Bar Harbor
Watson, Charles J.,	Thomaston

Councilor Reports

Report of Councilor, First District

To the Officers and Members of the Maine Medical Association:

I wish to submit the following report for the Cumberland and York County Medical Societies:

Both societies have held the usual stated meetings with a notable increase in attendance.

Cumberland, with meetings at the Portland Hospitals, has had a parade of distinguished out of state speakers. Records of these meetings have been previously published in the JOURNAL.

York, with only quarterly meetings, has had Portland doctors as speakers, namely: Harry E. Christensen, M. D., Albert C. Johnson, M. D., and Eugene P. McManamy, M. D., each speaking on his specialty while a member of the Maine General Hospital Unit overseas.

Dr. Frederick R. Carter, Secretary-Treasurer of the Maine Medical Association, has been a frequent and welcome visitor at the meetings in both counties, and his advice and knowledge has aided in discussions of local, state, and national medical issues.

Respectfully submitted,
CARL E. RICHARDS, M. D.,
Councilor, First District.

Report of Councilor, Second District

To the Officers and Members of the Maine Medical Association:

The Second District, which includes Androscoggin, Oxford and Franklin Counties, has evinced much more interest in county and state affairs than for several years previous. This, of course, is in part due to the fact that many members have returned from the armed service and conditions are more normal.

Androscoggin County has held eight meetings, which have been well attended.

In October, Dr. Charles N. Branch of Boston gave an interesting talk on the Children's Hospital of Boston.

In November, Dr. Francis A. Winchenbach of Bath gave an informative talk on the activities of the National Physicians' Committee.

The December meeting was addressed by Dr. Allan Butler of Boston on Medical Legislation in Congress.

In March, Mr. W. Mayo Payson, Executive Secretary of the Maine Medical Association, gave an interesting report on legislative procedures in this session of the legislature.

In April, Dr. Edwin Kay of the Oxford County Medical Society gave a timely paper on the endocrines.

The May meeting was conducted by a panel of Portland doctors. Papers discussing different types of cancer were read by Dr. Eugene P. McManamy, Dr. Theodore C. Bramhall, Dr. James M. Parker and Dr. Isaac M. Webber.

Oxford County has had two meetings.

The June meeting will be of especial interest as always.

In Franklin County two meetings have been held.

Besides these meetings subjects of county and state interest are discussed at the hospital staff meetings at Farmington at which a good part of the county members are present.

Respectfully submitted,
R. A. GOODWIN, M. D.,
Councilor, Second District.

Report of Councilor, Third District

To the Officers and Members of the Maine Medical Association:

My report is brief and unexciting. Unable to visit the Lincoln-Sagadahoc Society I have no personal observation to record.

The Knox County Society has enjoyed a busy year with monthly meetings well attended and with warm interest manifest.

Respectfully submitted,
C. HAROLD JAMESON, M. D.,
Councilor, Third District.

Report of Councilor, Fourth District

To the Officers and Members of the Maine Medical Association:

The Annual Meeting of the Kennebec County Medical Society was held at the Augusta State Hospital on December 19, 1946. At the time, Dr. Frank B. Bull was elected President; Dr. William L. Gousse, Vice President; and Dr. A. H. Morrell, Secretary and Treasurer.

The Kennebec County Society is one of the outstanding societies in our Association. Meetings are held every month. Some of the meetings have been addressed by outstanding men from our state, and at other times we have had out of state speakers of national prominence. The meetings have been well attended and following the various papers which have been presented there has been an unusual amount of discussion and interest.

Somerset County: No meeting has been held during the year.

Waldo County: The annual meeting was held in January, 1947. Dr. Seth H. Read of Belfast was elected President, and Dr. R. L. Torrey of Searsport was elected Secretary. Dr. Joseph E. Porter, of Portland, addressed the society giving a very interesting talk which was well discussed.

Respectfully submitted,
ROLAND L. MCKAY, M. D.,
Councilor, Fourth District.

Report of Councilor, Fifth District

To the Officers and Members of the Maine Medical Association:

There has been one meeting of the Washington County Society, since my appointment to the Council, which I attended. There were about ten members present, neither the President nor the Secretary being there. Dr. W. N. Miner of Calais was appointed chairman and an informal discussion of Medical Association problems was entered into. The affairs of the Medical Association were approved and encouraged and it is the hope of this Association to have more meetings and more activity for the coming years.

On two occasions, I attended meetings at Ellsworth, of the Hancock Medical Association and think what interested me most there was the energy being expended in the effort to establish a hospital in Ellsworth to represent the County, and the ambitious program to raise $400,000. which is being planned. The

whole program is being carefully worked out and it is the hope of the doctors in Ellsworth that this program will succeed. Dr. George Holmes entered into this discussion of hospital requirements, giving much valuable advice. It is a pleasure to attend the meetings of the Hancock Association where so much enthusiasm is being displayed.

Respectfully submitted,

NORMAN E. COBB, M. D.,
Councilor, Fifth District.

Report of Councilor, Sixth District

To the Officers and Members of the Maine Medical Association:

In Aroostook County distances, and the long winter, make frequent meetings impractical. However, the county association is well organized. During the past year considerable work has been done on the question of unifying fees. The new state dues have been well collected and the association is approaching its annual meeting in a very healthy condition.

In Penobscot County, the usual eight meetings have been held with constantly increasing attendance. A new venture this year was the establishment of the Bangor Medical Club. One of the prime duties of the new club is to encourage the writing of medical papers and, to date, several most excellent papers have been presented. Collection of dues has been extremely high.

Piscataquis County kept intact its thirteen-year record for 100% payment of state and county dues. Four regular meetings have been held with excellent attendance. In August, a special meeting was held at Squaw Mountain Inn, to which were invited members from five surrounding counties. Discussions have been held relative to fees within the county and consideration has been given to affairs of the State association, including care of the veterans and the JOURNAL.

Respectfully submitted,

FORREST B. AMES, M. D.,
Councilor, Sixth District.

Committee Reports

Standing Committees

Public Relations Committee

To the Officers and Members of the Maine Medical Association:

The Public Relations Committee begs leave to submit the following report:—

Your committee has coöperated with similar committees from other organizations in the formation of the Maine Health Council and all of our activities have been carried out through this channel.

The organizations making up The Maine Health Council, in addition to our Association, are: The Maine Hospital Association, The Maine Dental Association, The Maine Public Health Association, The Maine Cancer Society, The Pine Tree Crippled Children's Society, The Associated Hospital Service of Maine and The State Department of Health and Welfare.

Each organization, execept the State Department, contributed $300. In addition the Bingham Associates made a generous contribution of $900. towards this work. The Council engaged an experienced newspaper man, Mr. Edward Talberth of Portland, on a part-time basis. He has effected news releases in all of the newspapers of the State, telling the story of each organization's activities. It is planned to add radio programs and to have a speakers' bureau available in the near future.

This seems to be the most effective way of developing good Public Relations and at the same time promoting a program of Health Education among the people. While only in operation a very few months, we feel that a great deal has been accomplished.

This seems to be about the first time that our Association has ever attempted to do anything in the important field of Public Relations. As this program develops its worth will be self-evident.

Respectfully submitted,

ROLAND L. MCKAY, M. D., Augusta,
HENRY C. KNOWLTON, M. D., Bangor,
HENRY P. JOHNSON, M. D., Portland,
JOSEPH A. DONOVAN, M. D., Houlton,
FREDERICK T. HILL, M. D., Waterville,
Chairman.

Special Committees

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

The Committee on Graduate Education begs leave to submit the following report:—

Your committee decided upon six major objectives for its work this past year:

1. Rendering assistance to physicians desiring refresher courses, and making recommendations for financial assistance when indicated.

2. Further development of hospital staff meetings and bringing these to the attention of members through the JOURNAL.

3. The inclusion of clinico-pathological reports from the various hospital groups in the JOURNAL each month (to be in charge of Dr. Porter).

4. Articles on "Progress in Medicine" to be made available for the JOURNAL each month (in charge of Dr. Comeau).

5. Preparation of six panel discussions to be made available for county meetings, as follows:—

"Results to be Expected in the Treatment of Early Recognized Malignancy" Joseph E. Porter, M. D., *Chairman*
"Coronary Disease" W. J. Comeau, M. D., *Chairman*
"Thoracic Injuries" G. E. Young, M. D., *Chairman*
"The Acute Abdomen" .. W. V. Cox, M. D., *Chairman*
"Renal Disease" E. R. Blaisdell, M. D., *Chairman*
"Deafness" F. T. Hill, M. D., *Chairman*

These have met with varying degrees of success. Assistance to physicians desiring refresher courses has been rendered upon an individual basis and has largely consisted of offering desired advice and information as to where courses might be available.

The clinico-pathological reports for the JOURNAL have been compiled by Dr. Porter and would seem to have been a valuable addition to its pages. The Progress articles, in charge of Dr. Comeau, have been inaugurated and should be continued during the coming year.

We have hoped to further improve the teaching quality of our hospital staff meetings as this is a very fertile field for Continuation Education. Varying progress has been made here.

Much to our disappointment there has been little or no call for the Panels prepared for County meetings. Whether this was due to an unhappy selection of subjects or to inertia upon the part of County Association officials, we are unable to say. It does seem to us that a greater effort should be made to provide teaching programs for these meetings.

The revival of the N. E. Postgraduate Medical Assembly in Boston last Fall proved a welcome and valuable addition to our Continuation Program of Medical Education. A considerable number of our physicians were in attendance and all felt well repaid for the effort. Plans for even a better program are underway for this coming Fall. It is felt that our Association should participate most actively in this endeavor.

The mid-year Clinical Session of the Maine Medical Association sponsored by the Penobscot County Medical Association was held in Bangor on December 1 and 2, 1946. A social meeting and dinner for members and wives inaugurated the Session on the evening of December first. Clinical material was presented in the form of papers and wet clinics at the Eastern Maine General Hospital on December 2nd. The Bangor Sanatorium and the Bangor State Hospital also presented clinical programs in conjunction with the Session. Chester Keefer, M. D., Professor of Medicine at the Boston University School of Medicine, and Ralph Adams, M. D., of the Surgical Department of the Lahey Clinic were discussants during the day and were the principal speakers at the banquet on the evening of December 2, 1946, which closed the Session, at which 103 members registered.

Respectfully submitted,

Eugene H. Drake, M. D., Portland,
Joseph E. Porter, M. D., Portland,
William V. Cox, M. D., Auburn,
Magnus F. Ridlon, M. D., Bangor,
Wilfrid J. Comeau, M. D., Bangor,
George E. Young, M. D., Skowhegan,
Frederick T. Hill, M. D., Waterville,
Chairman.

Committee on Maternal and Child Welfare

To the Officers and Members of the Maine Medical Association:

The Committee on Maternal and Child Welfare have not held a meeting during the year.

Members of the committee have, however, given substantial aid to the Maine Study of Child Health Services being conducted by the American Academy of Pediatrics. The results of this study will be published in The Journal of the Maine Medical Association later in the year.

Respectfully submitted,

Clair S. Bauman, M. D., Waterville,
Leroy C. Gross, M. D., Auburn,
Alice A. S. Whittier, M. D., Portland,
Virginia C. Hamilton, M. D., Bath,
Theodore M. Stevens, M. D., Portland,
Thomas A. Foster, M. D., Portland,
Chairman.

Committee on Study of Prepaid Medical Care

To the Officers and Members of the Maine Medical Association:

The House of Delegates, in June, 1946, voted to continue investigation of voluntary health insurance. The special committee appointed by the Council was reappointed by the President with one substitution. The subject in question has been under investigation.

It was decided to petition the Legislature for an enabling act which would make it possible to set up an insurance plan if the members of the Association decided to do so. The Bill was drawn by the Executive Secretary, Mr. W. Mayo Payson, and was presented by Senator George B. Morrill to the 93rd Legislature, being known as Legislative Document No. 968, and Bill was referred to the Judiciary Committee. Members of your committee attended and spoke at a hearing on the Bill, which was opposed on the ground that it was discriminatory and non-inclusive. Members of the Association were asked to write personal letters to Legislators. The Bill was reported unfavorable, with a favorable minority report filed by one Senator, and was tabled in the Senate. The measure was subsequently taken from the table, was debated in the Senate and was defeated.

Respectfully submitted,

George O. Cummings, M. D., Portland,
Frank A. Smith, M. D., Westbrook,
Edward L. Herlihy, M. D., Bangor,
Clyde I. Swett, M. D., Island Falls,
M. Tieche Shelton, M. D., Augusta,
Eugene H. Drake, M. D., Portland,
Chairman.

Committee for Re-opening of a Medical School in Maine

To the Officers and Members of the Maine Medical Association:

The Committee for the re-opening of a Medical School in Maine was appointed by Dr. John Piper, President of the Maine Medical Association, at the last meeting of the society.

Its purpose was to start a Medical School at the University of Maine. A great deal of ground work was done throughout the state in familiarizing the public and the legislators with the project. The bill had the backing of the State Grange, the American Legion, the Veterans of Foreign Wars, and many other societies. There was no organized opposition.

The bill was sponsored by Senator Ruth Clough of Bangor who handled it very ably. Without the passage of a State sales or income tax or a combination of the two, we knew from the beginning there was no chance of passage. The bill was kept alive by the able handling of Senator Clough and Mr. Mayo Payson until the final day of the legislature, until we were absolutely certain there was no further chance of new tax money.

A bill was then substituted to create a commission to study the project for the next two years. This commission is to be composed of three representatives of the University of Maine, three doctors from the Maine Medical Association, and three civilians, with an appropriation of $1,000 for expenses.

The results accomplished by the committee were far from discouraging. There was marked legislative support and widespread public interest. If and when money is available, we have no doubt that the prospects of a Medical School in Maine are bright.

Respectfully submitted,

Edward L. Herlihy, M. D.,
Chairman.

Tuberculosis Committee

To the Officers and Members of the Maine Medical Association:

I wish to report as Chairman of the Tuberculosis Committee that a luncheon meeting was held at

Poland Spring, during the 1946 annual session of the Maine Medical Association, at which the following Doctors were appointed in each County Medical Society:

Androscoggin County: Drs. Blinn W. Russell, Bertrand A. Beliveau, and Michael J. Harkins.

Aroostook County: Drs. Storer W. Boone, William B. Kirk, and Clyde I. Swett.

Cumberland County: Drs. Francis J. Welch, Edward A. Greco, and Thomas A. Foster.

Franklin County: Drs. George L. Pratt, Herbert M. Zikel, and Kenneth A. LaTourette.

Hancock County: Drs. Philip L. Gray, Ernest L. Coffin, and James H. Crowe.

Kennebec County: Drs. Wilson H. McWethy, Ivan E. McLaughlin, and Theodore E. Hardy.

Knox County: Drs. Frederick C. Dennison, Paul A. Millington, and Oram R. Lawry, Jr.

Lincoln-Sagadahoc: Drs. James W. Laughlin, Edward M. Fuller, Jr., and Thomas E. Proctor.

Oxford County: Drs. Lester Adams, William T. Rowe, and Roswell E. Hubbard.

Penobscot County: Drs. Albert W. Fellows, John J. Pearson, and Walter R. Gumprecht.

Piscataquis County: Drs. William B. S. Thomas, Guy E. Dore, and Norman H. Nickerson.

Somerset County: Drs. George E. Young, Paul R. Briggs, and Richard P. Laney.

Waldo County: Drs. Seth M. Read, Raymond L. Torrey, and John A. Caswell.

Washington County: Drs. Norman E. Cobb, DaCosta F. Bennett, and James C. Bates.

York County: Drs. Edward W. Holland, James H. Macdonald, and Stephen A. Cobb.

During the summer the members of the committee and their wives were entertained by Dr. Lester Adams, and his staff, at the Western Maine Sanatorium where a fine dinner was served. A very instructive meeting was held with motion pictures on Mass Radiography. Dr. Norman Wilson, of Boston, was a guest.

There will be a luncheon meeting of the committee at the Marshall House, York Harbor, Maine, during the 1947 annual meeting of the Maine Medical Association.

Respectfully submitted,

Francis J. Welch, M. D., Portland,
Chairman.

Veterans' Affairs Committee

To the Officers and Members of the Maine Medical Association:

The House of Delegates of the Maine Medical Association, meeting at Poland Spring, June 24, 1946, authorized the Veterans' Affairs Committee of the Maine Medical Association to hold conference with officials of the Veterans' Administration, and the Associated Hospital Service of Maine, and review proposed service contracts for medical care of veterans. A meeting was held at Togus, Maine, July 11, 1946, and the contracts were carefully discussed and some apparent ambiguity of wording and intent was studied.

As a result of the above meeting, the Veterans' Affairs Committee of the Maine Medical Association recommended that the contracts be approved and that members of the Maine Medical Association be urged to participate in the plan. The Council of the Maine Medical Association, meeting in Augusta, August 4, 1946, further studied the question and voted to approve; assurances being given that the Associated Hospital Service of Maine, a lay organization, is to serve merely as a business liaison between the Veterans' Administration and the members of the Maine Medical Association who wish to participate and sign the contract to render medical service to properly authorized veterans.

The following points are of interest:

Veterans' Administration to Use Veteran's Family Doctor.

Pursuant to agreements in the contracts, the Veterans' Administration plans that home and office medical care of veterans may be given by the veteran's own doctor in his own community. This state-wide plan marks a great step forward in the Veterans' Administration program of decentralization and of recognition of the physician-patient relationship. This is a project which merits support of every member of the Maine Medical Association.

Procedure

The veteran will apply for medical care by mail (or by phone in emergencies) to the *Veterans' Administration.* He will receive a case number permitting him to obtain a medical examination from his own doctor of medicine. After the examination (to determine disability and to what degree) he will obtain authorization from the Veterans' Administration for treatment.

Authorizations

Doctors will receive the authorizations from the Veterans' Administration, through the office of the Associated Hospital Service of Maine (Veterans' Care Department) which will act as a central fiscal agency for handling the necessary reports and accounts. A fee schedule, approved by the Council of the Maine Medical Association, will be followed. A copy of this schedule has already been placed in the hands of each doctor in the State Association. Recently a new fee schedule has been submitted with an increase in fees in most instances.

Eligibility

Male veterans with service-connected disabilities, and conditions which aggrevate service-connected disabilities, are eligible for service; female veterans with both service and non-service-connected disabilities will be given care under this plan (since the Veterans' Administration Hospital in Maine is for men only). This plan will cover all medical and surgical care.

Restrictions

1. Specialists' care is available on special authorization and at the request of the family physician.

2. No transportation is paid to veterans who seek medical service elsewhere than in their home communities, except on special authorization by the Veterans' Administration.

3. Female veterans are not covered for pregnancy.

4. Veterans' dependents are not covered.

Further Points of Interest

1. *The above plan will include only members of the Maine Medical Association.*

2. The Associated Hospital Service of Maine is acting merely as a central fiscal agency to relieve doctors, the Maine Medical Association, and the Veterans' Administration of the necessary bookkeeping in connection with the care of veterans by their own family physician.

3. It is contemplated that after this plan is in operation considerable paper work will be eliminated.

4. The Associated Hospital Service of Maine has no power to authorize or otherwise regulate treatment of veterans. Such matters are to be handled exclusively by the Veterans' Administration.

Recommendation

We believe that the agreements above outlined will offer opportunity for rendering the best possible care

to the veterans, and by retention of the physician-patient relationship, will further the cause of the private practice of medicine in Maine.

Contracts covering medical services have been distributed to members of the Maine Medical Association.

We urge all members not participating in the plan to sign contracts with the Associated Hospital Service of Maine for listing.

Some difficulty was experienced at first with non-payment, or shall we say lapse of time between the service rendered and payment received. This to a great extent has been remedied.

The committee also recommends that the new fee schedule be adopted.

Respectfully submitted,

HAROLD E. PRESSEY, Bangor, Maine,
Chairman,
ELTON R. BLAISDELL, Portland, Maine,
CURRIER C. WEYMOUTH, Farmington, Maine,
FRANCIS A. WINCHENBACH, Bath, Maine.
EDWARD H. RISLEY, Waterville, Maine,
PHILIP O. GREGORY, Boothbay Harbor, Maine.

Report of the Secretary-Treasurer

To the Officers and Members of the Maine Medical Association:

As your Secretary and Treasurer, I am pleased to submit the following report:

There are 701 active members in good standing in the Association; 31 Honorary and eight in Military Service, making a total of 740 members. Sixty-one new members have been added to our roster during the past year. We have lost ten by death, and eleven have moved out of the State.

The following County Medical Societies are to be commended for 100% payment of dues: Piscataquis, Waldo, Hancock, Oxford, and York.

The 1946 Clinical Session was held at Bangor, Maine, December 1st and 2nd. Clinics held at the Eastern Maine General Hospital, Bangor State Hospital and Bangor Sanatorium, were very interesting and instructive. Guest speakers at the evening session, December 2nd, were Chester S. Keefer, M. D., of the Evans Memorial Hospital, Boston; and Ralph Adams, M. D., of the Lahey Clinic, Boston.

The Ninety-third annual session of the Maine Medical Association will be held at the Marshall House, York Harbor, Maine, June 22nd, 23rd, and 24th. An excellent program, to be found elsewhere in this issue of the JOURNAL, has been prepared by the Scientific Committee, of which Dexter E. Elsemore, M. D., of Dixfield, is Chairman.

The report of the Council for 1946-1947 will be presented by the Chairman, Forrest B. Ames, M. D., of Bangor, at the First Meeting of the House of Delegates, Sunday, June 22nd, at 3.00 P. M.

The Association will have the pleasure of presenting Fifty-Year Service Medals to the following members at the annual dinner Tuesday evening, June 24th: Louis N. Albert, M. D., William O. Cobb, M. D., Harry S. Emery, M. D., Louis B. Hayden, M. D., Walter S. Milliken, M. D., Clarence C. Peaslee, M. D., Harry L. Prescott, M. D., Ward J. Renwick, M. D., and Hedley V. Tweedie, M. D.

All space allotted for Commercial Exhibits has been reserved. This will be the largest exhibit in the history of the Association, and I hope that the members will make a special effort to visit them.

Your Secretary wishes to report his appreciation for the coöperation of the County Society Officers, and to the Councilors and other Officers of the Association, in carrying on the work of the Association during the past year.

The books of the Association and JOURNAL were closed and audited as of May 31, 1947, by Jordan and Jordan, Accountants and Auditors, and were found to be complete and correct in all details of record. Their complete report, to be published in the July issue of the JOURNAL, will be in our hands before the annual meeting and will be available to any member of the Association.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary-Treasurer.

May 31, 1947.

IF ADVERTISED IN THE

JOURNAL

IT IS GOOD

Call On Some Doctors, Son . . . — Continued from page 137

come and a checking account in a bank. Until now this was available only through Payroll Savings. It operates this way:

The depositor who wishes to buy a bond each month signs a card authorizing the bank to deduct the purchase price from his checking account. The bank issues the bonds and delivers them to the customer monthly. The periodic bank statement shows payment for the bonds.

And from the first and the only time the doctor signs his authorization card, he has nothing else to do except open the envelopes the bank sends him with the bonds inside.

What does the doctor need?

1. He needs some sort of arrangement for his financial future because, according to studies of his profession, incomes of physicians are much more responsive to change in the national income than are the incomes in other professions. If the national income drops and patients no longer can afford to call on the doctor so often or to pay him as quickly, a doctor's bankbook will feel the change.

2. In most instances, the doctor has no social security or pension to fall back on. Thus, he needs something to serve as an old-age reserve.

3. He needs simplicity — an arrangement which does not call for continual checking, manipulating, buying and selling.

4. He needs safety. He cannot afford to take the risks which must be protected by constant market vigilance, by buying and selling strategically.

A savings bond plan should be the foundation upon which the doctor builds his security. There is no safer investment in the world than Savings Bonds. There is no riskless investment which pays such a guaranteed return.

Consider:

If you invest monthly under the Bond-a-Month Plan	In five years you will have	In ten years you will have
$ 37.50	$ 2,319.00	$ 4,998.00
75.00	4,638.00	9,996.00
150.00	9,276.00	19,992.00
300.00	18,552.00	39,984.00

Here, for the doctor himself, are vitamins E, F and G, thoroughly tested and always compounded with interest. These "vitamins" ease common symptoms of post-middle age such as chronic worry and doubt. They are available at a bank near you. And with millions of current users, we can make this unusual guarantee: one and a third times your money back if you *are* satisfied.

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Program

93rd ANNUAL SESSION
MAINE MEDICAL ASSOCIATION

JUNE 22, 23, 24, 1947

MARSHALL HOUSE

York Harbor, Maine

PROGRAM ARRANGED

by the

SCIENTIFIC COMMITTEE

Dexter E. Elsemore, M. D., *Chairman*
Francis A. Winchenbach, M. D.
Martyn A. Vickers, M. D.
Theodore E. Hardy, M. D.
Frederick R. Carter, M. D., *Secretary, ex-officio*

INFORMATION

Registration:

Registration headquarters will be in the Lobby of the Marshall House. Every member and guest is requested to register and receive a badge on arrival.

Papers:

All papers read before this Association shall be its property for publication in "The Journal of the Maine Medical Association," and when read shall be deposited with the Secretary, Dr. Frederick R. Carter.

SUNDAY, JUNE 22, 1947

3.00 P. M.

First Meeting of the House of Delegates

7.00 P. M.

Dinner

8.30 P. M.

Guest Speaker:

Edward F. Stegen, Associate Administrator, National Physicians' Commttee.

Subject: "American Medicine in Transition"

Motion Picture:

"America, The Beautiful"

Shown by Harvey M. Fickett, U. S. Treasury Department

MONDAY, JUNE 23, 1947

Morning Session

9.00 A. M.

General Assembly:

President John O. Piper, M. D., presiding

Announcements:

Dexter E. Elsemore, M. D., Chairman, Scientific Committee

Frederick R. Carter, M. D., Secretary

9.30 A. M.-12.00 M.

CONFERENCES

I

ANESTHESIA

Chairman: Gilbert Clapperton, M. D., Lewiston

Subject: "Spinal Anesthesia"

Speakers:

Dominique Mentel, M. D., Lewiston

Thomas Fay, M. D., Lewiston

II

EAR, NOSE AND THROAT

Chairman: Frederick T. Hill, M. D., Waterville

Subject: Panel Discussion—"Deafness"

1. Causes and Types
 George O. Cummings, M. D., Portland
2. Prevention
 Pierre Provost, M. D., Augusta
3. Conventional Procedures in Treatment
 Henry P. Johnson, M. D., Portland
4. Hearing Aids
 John E. Whitworth, M. D., Bangor
5. Fenestration
 Merton N. Flanders, M. D., Waterville

III

GENERAL MEDICINE

Chairman: Theodore E. Hardy, M. D., Waterville

Subject: Panel Discussion—"Infectious Hepatitis"

1. Etiology and Pathology
 Irving Goodof, M. D., Lewiston
2. Clinical Features and Physical Findings
 Elton R. Blaisdell, M. D., Portland
3. Differential Diagnosis
 Charles W. Steele, M. D., Lewiston
4. Treatment
 Eugene H. Drake, M. D., Portland
5. Summary
 G. G. Duncan, M. D., Philadelphia, Pa.

IV

ORTHOPEDICS

Chairman: Thomas A. Martin, M. D., Portland

1. Low Back Pain. A Diagnostic Problem
 Carl W. Ruhlin, M. D., Bangor
2. Slipped Capital Femoral Epiphysis
 Morris Goldman, M. D., Lewiston
3. Subject to be announced
 Samuel S. Silsby, M. D., Bangor

V

GYNECOLOGICAL—OBSTETRICAL

Chairman: Theodore C. Bramhall, M. D., Portland

Subject: "Sterility"

1. General Discussion
 Theodore C. Bramhall, M. D., Portland

2. Anatomical and Special Tests of the Female Genital Tract
 Magnus F. Ridlon, M. D., Bangor
3. Endocrinology
 K. Alexander Laughlin, M. D., Portland
4. Urological
 Donald F. Marshall, M. D., Portland

Luncheon

12.30 P. M.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill, Vermont, Tufts, Yale and Harvard Medical Schools, and members of the Tumor Clinics.

Afternoon Session

2.00-5.00 P. M.

Scientific Session

1. Treatment of Acute Complications of Diabetes
 G. G. Duncan, M. D., Philadelphia, Pa.
2. Management of Obstructive Jaundice
 Richard B. Cattell, M. D., Boston, Mass.
3. The Problem of the Ruptured Intervertebral Disc
 George F. Maltby, M. D., Portland

5.00 P. M.

Election of President-elect

5.30 P. M.

Second Meeting of the House of Delegates

Evening Session

7.00 P. M.

Dinner

Guest Speakers:

Winthrop Adams, M. D.
Subject: "Medical and Hospital Care of Veterans under Veterans' Administration"

Miss Esther Lipton, Department of Education, Augusta
Subject: To be announced

TUESDAY, JUNE 24, 1947

Morning Session

9.30 A. M.-12.00 M.

CONFERENCES

I

Annual Meeting of the Maine Medico-Legal Society

President, Roland L. McKay, M. D.
President-elect, Richard Chapman, County Attorney, Cumberland County
Secretary, George L. Pratt, M. D.
Treasurer, Walter S. Stinchfield, M. D.

Program:

Business Meeting (9.00 A. M.)
Reports of Secretary, Treasurer and Executive Committee
Election of Officers

Address: **A. Warren Stearns, Department of Sociology, Tufts College**
Subject: "The Life and Crimes of Jesse Harding Pomeroy"

Address: **LeMoyne Snyder, M. D., Medico-Legal Director, Michigan State Police**
Subject: "Medicine and Homicide Investigation"

II

Allergy

Chairman. **Martyn A. Vickers, M. D., Bangor**

1. Food Allergy
 Abraham Colmes, M. D., Boston, Mass.
2. Pediatric Allergy
 Edward O'Keefe, M. D., Lynn, Mass.
3. Allergy in Relation to Diseases of the Skin
 Martyn A. Vickers, M. D., Bangor

III

Eye

Chairman: **Warren E. Kershner, M. D., Bath**

Speaker: **Howard F. Hill, M. D., Waterville**

IV

General Surgery

Chairman: **Edward L. Herlihy, M. D., Bangor**

Subject: Symposium on Gall Bladder Disease

1. Anatomy and Newer Physiological Concepts
 Howard R. Ives, M. D., Portland
2. Surgical Gall Bladder Disease and Diagnosis
 Waldo A. Clapp, M. D., Lewiston
3. X-ray Studies of the Gall Bladder Tract
 Hugh Smith, M. D., Bangor
4. Operative Procedure
 Clyde I. Swett, M. D., Island Falls
5. End Results of 100 Cases
 Richard T. Munce, M. D., Bangor
6. Discussion
 Richard B. Cattell, M. D., Boston, Mass.

OVER

V

UROLOGY

Chairman: Joseph Memmelaar, M. D., Bangor

1. Renal Tumors
 Eugene McGregor, M. D., Portland
2. Treatment of Cancer of the Prostate
 Roderick L. Huntress, M. D., Portland
3. Primary Closure in Perineal Prostatectomy
 J. Foster Wellington, M. D., Portland
4. Hematuria
 Donald F. Marshall, M. D., Portland
5. Interesting Urological Specimens and X-ray Pictures
 Carl E. Blaisdell, M. D., Bangor
 Joseph Memmelaar, M. D., Bangor

VI

PEDIATRICS

Chairman: Glidden L. Brooks, M. D., Lewiston

1. State Services for Children
 Ella Langer, M. D., Augusta
 Discussed by Thomas A. Foster, M. D., Portland
2. Influenzal Meningitis
 Philip G. Good, M. D., Portland
 Discussed by Glidden L. Brooks, M. D., Lewiston
3. Pyloric Stenosis
 Gerald H. Donahue, M. D., Presque Isle
 Discussed by Albert W. Fellows, M. D., Bangor
4. Anesthesia in Children
 Gilbert Clapperton, M. D., Lewiston
 Discussed by Francis A. Winchenbach, M. D., Bath
5. A Case of Rh Incompatibility
 Rudolf Toch, M. D., and Theodore S. Golden, M. D., Lewiston
 Discussed by Joseph E. Porter, M. D., Portland

Afternoon Session

2.00-5.00 P. M.

SCIENTIFIC SESSION

1. President's Address
 John O. Piper, M. D., Waterville
2. Treatment of Hyperthyroidism
 E. B. Astwood, M. D., Boston, Mass.
3. Diagnosis and Treatment of Mediastinal Tumors
 Richard H. Sweet, M. D., Boston, Mass.

Evening Session

8.00 P. M.

Annual Dinner

Presentaion of Fifty-Year Medals by President John O. Piper, M. D.

Guests Speakers:

Governor Horace A. Hildreth

Professor Julius S. Bixler, Colby College, Waterville

Subject: "Salvaging the Modern Mind"

Special Notices

Fifty-Year Service Medals

Fifty-Year Service Medals will be presented to the following members at the Annual Dinner, Tuesday evening, June 24th.

Androscoggin County Medical Association

Louis B. Hayden, M. D., Livermore Falls
Tufts College Medical School, 1897

Clarence C. Peaslee, M. D., Auburn
Bowdoin Medical School, 1897

Ward J. Renwick, M. D., Auburn
Cleveland University of Medicine and Surgery, 1897

Aroostook County Medical Society

Louis N. Albert, M. D., Van Buren
Laval University Faculty of Medicine, 1897

Cumberland County Medical Society

Harry S. Emery, M. D., Portland
Jefferson Medical College of Philadelphia, 1897

Kennebec County Medical Association

William O. Cobb, M. D., Gardiner
Dartmouth Medical School, 1897

Knox County Medical Society

Hedley V. Tweedie, M. D., Rockland
Baltimore Medical College, 1897

Somerset County Medical Society

Walter S. Milliken, M. D., Madison
Baltimore Medical College, 1897

York County Medical Society

Harry L. Prescott, M. D., Kennebunkport
Bowdoin Medical School, 1897

Program for the Ladies

Registration

Program

A special program has been arranged by Dr. Carl E. Richards, of Alfred, which will include a Sea Trip, and visits to gardens and old homes.

Official Delegates, 1947

County Medical Societies

FIRST DISTRICT

Cumberland County

Delegates: (One Year)
G. E. C. Logan, Portland
Wilbur F. Leighton, Portland
Francis W. Hanlon, Portland

(Two Years)
Oscar R. Johnson, Portland
Maurice J. Dionne, Brunswick
James M. Parker, Portland
Ervin A. Center, Steep Falls

Alternates: (One Year)
Eaton S. Lothrop, Portland
Henry M. Tabachnick, Portland
Donald G. Wight, South Portland

(Two Years)
Kenneth E. Dore, Fryeburg
Louis A. Asali, Portland
Carl E. Dunham, Portland
Harry E. Davis, Portland

York County

Delegates:
James H. Macdonald, Kennebunk
Charles W. Kinghorn, Kittery
David E. Dolloff, Biddeford

Alternates:
Paul S. Hill, Jr., Saco
Oscar W. Perrault, Biddeford
Alexander W. Magocsi, York Village

SECOND DISTRICT

Androscoggin County

Delegates:
Edson B. Buker, Auburn
Merrill S. F. Greene, Lewiston
Daniel F. D. Russell, Leeds

Franklin County

Delegate:
George F. Pratt, Farmington

Alternate:
Cecil F. Thompson, Phillips

Oxford County

Delegates: (One Year)
Delbert M. Stewart, South Paris

(Two Years)
Lester Adams, Hebron

Alternates: (One Year)
Garfield G. Defoe, Dixfield

(Two Years)
Henry M. Howard, Rumford

THIRD DISTRICT

Knox County

Delegates:
Paul A. Millington, Camden
Freeman F. Brown, Sr., Rockland

Lincoln-Sagadahoc Counties

Delegate:
Francis A. Winchenbach, Bath

FOURTH DISTRICT

Kennebec County

Delegates: (One Year)
Clarence R. McLaughlin, Gardiner

(Two Years)
Thomas C. McCoy, Waterville

(Three Years)
Theodore E. Hardy, Waterville

Alternate:
Wilson H. McWethy, Augusta

Somerset County

Delegates:
George E. Young, Skowhegan
Richard P. Laney, Skowhegan

Alternate:
Walter S. Stinchfield, Skowhegan

Waldo County

Delegate:
Foster C. Small, Belfast

Alternate:
Carl H. Stevens, Belfast

FIFTH DISTRICT

Hancock County

Delegate:
James H. Crowe, Ellsworth

Alternate:
Philip L. Gray, South Brooksville

Washington County

Delegate:
John F. Hanson, Machias

Alternate:
James C. Bates, Eastport

SIXTH DISTRICT

Aroostook County

Delegates:
P. L. B. Ebbett, Houlton
Clyde I. Swett, Island Falls

Alternates:
Lloyd H. Berrie, Caribou
Storer W. Boone, Presque Isle

Penobscot County

Delegates:
George B. Weatherbee, Hampden Highlands
Martyn A. Vickers, Bangor
John E. Smith, Bangor
Lawrence M. Cutler, Bangor

Alternate:
William A. Purington, Bangor

Piscataquis County
Delegate:
Ralph C. Stuart, Guilford
Alternate:
Philip B. Thomas, Monson

Association Delegates to 1947 Annual Sessions

American Medical Association
Thomas A. Foster, Portland

Connecticut State Medical Society
Wedgwood P. Webber, Lewiston

Massachusetts Medical Society
George E. Young, Skowhegan

New Hampshire Medical Society
Charles W. Kinghorn, Kittery

Rhode Island Medical Society
Alvin A. Morrison, Portland

Vermont State Medical Society (1946)
Merton N. Flanders, Waterville

Commercial Exhibits, Ninety-third Annual Session

The Alkalol Company, Taunton, Massachusetts.

Elmer N. Blackwell, Surgical Appliance Specialist, 207 Strand Building, Portland 3, Maine.

For 21 years Blackwell's has provided the medical profession with a complete service in Surgical and Corrective Appliances. You can depend on Blackwell's for the latest improvements in Abdominal and Back Supports, Elastic Hosiery, Trusses, Arches, Braces, and Women's Corset Supports at reasonable prices. Blackwell's guarantee quick and satisfactory mail order service and all appliances sent out are ready to fit. Be sure to see our exhibit and consult Mr. Blackwell about your cases needing corrective support. We offer you an opportunity to personally learn about our service which doctors are using with success.

The Borden Company, 350 Madison Avenue, New York 17, N. Y.

GERILAC, a vitamin-fortified powdered milk for well-rounded nutrition in convalescence, pre-and post-operative diets, geriatrics, pregnancy and lactation, and soft and liquid diets, is being introduced to the medical profession in Maine. GERILAC has a pleasing bland taste and variety may be enjoyed by the addition of flavors, such as vanilla, chocolate, etc. It may be served either as a beverage or used in cooking and baking. Also, Borden's offers BIOLAC, a liquid modified milk for infant feeding; DRYCO with its high-protein, low-fat content for formula flexibility; Mull-Soy, a liquid hypoallergenic soy food for your milk allergic patients; powdered whole milk KLIM, a dependable source of whole milk; the improved milk sugar, BETA LACTOSE for carbohydrate supplementation; and the powdered MERRELL-SOULE PROTEIN and LACTIC ACID MILKS for special infant feeding cases.

Spend a few pleasant moments with Charlie Quinn at the Borden Booth.

Brewer & Company, Inc., 12 East Worcester Street, Worcester 4, Massachusetts.

This exhibit consists of specialties, centering around Thesodate, the original enteric-coated tablet of Theobromine Sodium Acetate, and, Luasmin, a combination of Theophylline Sodium Acetate, Phenobarbital and Ephedrine for the treatment of asthma. Also, Brewer Capsules and Ampuls, other specialties and standard pharmaceuticals manufactured by Brewer & Company, Inc., including a complete line of Vitamin preparations for internal use and injection. Gel-ets, the newest mode in oral vitamin therapy, are also featured.

Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

The Coca-Cola Company, Atlanta 1, Georgia.

Cowley Pharmaceuticals, Inc., 3 Winter Street, Worcester 4, Massachusetts.

F. A. Davis & Co., 1914-1916 Cherry Street, Philadelphia, Pennsylvania.

The DoHo Chemical Corporation, 58 Varick Street, New York 13, N. Y.

C. B. Fleet Co., 921-927 Commerce Street, Lynchburg, Virginia.

Phospho-Soda (Fleet), the pure, stable aqueous concentrate of the two U. S. P. Sodium Phosphates has been detailed to the medical profession for more than 50 years. Our representative, Mr. Raymond S. Carman, will welcome the opportunity of discussing with you its application in hepatic and gallbladder dysfunctions and in conditions requiring a saline laxative.

George C. Frye Company, 116 Free Street, Portland, Maine.

Holland-Rantos Company, Inc., 551 Fifth Avenue, New York, N. Y.

Lanteen Medical Laboratories, Inc., 900 No. Franklin Street, Chicago 10, Illinois.

This manufacturer will exhibit the improved LANTEEN FLAT SPRING DIAPHRAGM, natural and synthetic estrogenic hormone products, including ESTROGEL, HEXYPHEEN and HEXESTROL (Lanteen), as well as VI-TEENS products. Included in their VI-TEENS display are VI-TEENS HOMOGENIZED VITAMINS and FERRELEX.

Lederle Laboratories Division, 30 Rockefeller Plaza, New York 20, N. Y.

Eli Lilly and Company, Indianapolis 6, Indiana.

The Lilly exhibit this year features an interesting presentation on the heart and a discussion on cardiac drugs. Many Lilly products are to be on display; representative literature will be available. The attending Lilly medical service representatives will be pleased to assist visiting physicians whenever possible.

E. F. Mahady Company, 851-859 Boylston Street, Boston 16, Massachusetts.

Maine Surgical Supply Company, 10 Longfellow Square, Portland, Maine.

Harry E. Martin Company, 56 Exchange Street, Portland, Maine.

Mead Johnson & Company, Evansville 21, Indiana.

Picker X-Ray Corporation, 920 Beacon Street, Boston, Massachusetts.

Philip Morris & Co., Ltd., Inc., 119 Fifth Avenue, New York 3, N. Y.

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

The P. J. Noyes Company, Lancaster, New Hampshire.

Rare Chemicals, Inc., First and Essex Streets, Harrison, New Jersey.

Preparations exhibited by Rare Chemicals, Inc., will include Acidolate (non-lathering liquid) and Dermolate (new lathering cake), both non-irritating skin detergents; Arsenoferratose, palatable hematinic; Eucupin, local anesthetic with prolonged analgesic action; Gitalin, digitalis preparation; Salysal, antirheumatic analgesic, and Testosterone Propionate, "Rare Chemicals," androgenic preparation.

Thomas W. Reed Company, 91 Massachusetts Avenue, Boston, Massachusetts.

We are pleased to announce that our Mr. John F. Walsh, Waterville, Maine, will again be in charge of our exhibit at the annual convention of the Maine Medical Association to be held at the Marshall House, York Harbor, Maine, June 22, 23, 24, 1947.

Schering Corporation, 2 Broad Street, Bloomfield, New Jersey.

The Schering booth will feature the potent oral estrogenic hormone, *Estinyl* (ethinyl estradiol), the oral progestin, *Pranone* (anhydrogydroxyprogesterone), and the oral androgen,*Orcton-M* (methyltestosterone). The well-known parenteral hormone, *Orcton* (testosterone propionate), *Progymon B* (estradiol benzoate), *Proluton* (progesterone), and *Cortate* (desoxycorticosterone acetate) will also be displayed. The new effective treatment for ophthalmic infections, *Sodium Sulfacetimide Solution 30%* will be of interest as will be the clinically safer sulfonamide combination *Combisul-TD* and the radiographic media *Priodax* and *Neo-Iopax*. Schering Professional Service Representatives will be present to welcome physicians' inquiries.

G. D. Searle & Co., Chicago 80, Illinois.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be such time-proven products as Floraquin, Metamucil, Pavatrine, Pavatrine with Phenobarbital, Gonadophysin, and the complete dosage forms of Searle Aminophyllin.

E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

Surgeons' and Physicians' Supply Co., 761 Boylston Street, Boston 16, Massachusetts.

Tailby-Nason Company, 49 Amherst Street, Boston 42, Massachusetts.

U. S. Vitamin Corporation, 250 East 43rd Street, New York 17, N. Y.

Full color illustrated brochure "Diagnosing Vitamin Deficiencies" together with professional samples and literature on VI-SYNERAL, POLY-B, VI-LITRON, HYPERVITAM, LIPO-HEPLEX, DALSOL, DESIVER, AMIPROTE, and others.

The Zemmer Company, 3943-5-7 Sennott Street, Pittsburgh 13, Pennsylvania.

Convention Rates

The Marshall House

York Harbor, Maine

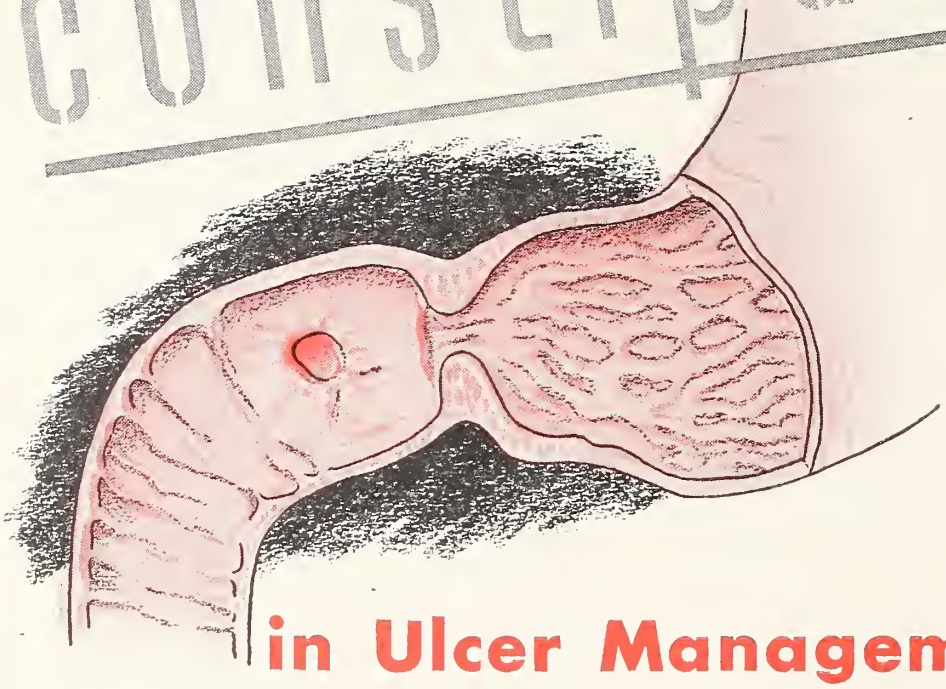
$10.50 a day per person. This rate to include meals.

Charge for non-registered guests for meals will be as follows:

Breakfast	$1.50
Luncheon	2.50
Dinner	3.00
Banquet	3.00

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—Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 199.

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SEARLE *RESEARCH IN THE SERVICE OF MEDICINE*

Official Roster

MAINE MEDICAL ASSOCIATION

Members ❦ Honorary Members ❦ Members in Military Service

May 31, 1947

ANDROSCOGGIN COUNTY

MEMBERS

Beeaker, Vincent,	85 Wood St., Lewiston
Beliveau, Bertrand A.,	100 Pine St., Lewiston
Beliveau, Romeo A.,	89 Pine St., Lewiston
Bernard, Romeo A.,	144 Pine St., Lewiston
Bousquet, Jean,	91 Bartlett St., Lewiston
Brien, Maurice,	80 Pine St., Lewiston
Brooks, Glidden L.,	300 Main St., Lewiston
Buker, Edson B.,	80 Goff St., Auburn
Busch, John J.,	105 Elm St., Mechanic Falls
Call, Ernest V.,	118 Pine St., Lewiston
Caron, Frederick J.,	174 Bates St., Lewiston
Cartland, John E.,	117 Goff St., Auburn
Cattley, Amy L.,	477 Main St., Lewiston
Chaffers, William H.,	190 Bates St., Lewiston
Chapin, Milan,	300 Main St., Lewiston
Chenery, Frederick L., Jr.,	Monmouth
Chevalier, Paul R.,	240 Lisbon St., Lewiston
Clapp, Waldo A.,	215 College St., Lewiston
Clapperton, Gilbert,	20 Ware St., Lewiston
Cox, William V.,	82 Gamage St., Auburn
Desaulniers, George E. D.,	106 Chestnut St., Lewiston
Fahey, William J.,	17 Frye St., Lewiston
Fortier, Paul J. B.,	70 Pine St., Lewiston
Frost, Robert A.,	2 Goff St., Auburn
Gauvreau, Horace L.,	82 Pine St., Lewiston
Gerrish, Lester P.,	Lisbon Falls
Giguere, Eustache N.,	108 Cedar St., Lewiston
Goldman, Morris E.,	487 Main St., Lewiston
Goodwin, Ralph A.,	56 Dennison St., Auburn
Gottlieb, Julius,	300 Main St., Lewiston
Grant, Alton L., Jr.,	133 Court St., Auburn
Greene, Merrill S. F.,	466 Main St., Lewiston
Gross, Leroy C.,	19 Goff St., Auburn
Haas, Rudolph,	344 Main St., Lewiston
Hanscom, Oscar E.,	Greene
Harkins, Michael J.,	437 Main St., Lewiston
Hayden, Louis B.,	Livermore Falls
Higgins, Everett C.,	149 College St., Lewiston
Hirshler, Max,	85 Pine St., Lewiston
James, Chakmakis,	133 College St., Lewiston
Lynn, Geraldine,	92 Pine St., Lewiston
Mandelstam, Abe W.,	17 Wakefield St., Lewiston
Methot, Frank P.,	256 Lisbon St., Lewiston
Miller, Hudson R.,	11 Turner St., Auburn
O'Connell, George B.,	133 Webster St., Lewiston
Peaslee, Clarence C.,	42 Goff St., Auburn
Poulin, J. Emile,	198 Lisbon St., Lewiston
Pratt, Harold S.,	Livermore Falls
Rand, Carleton H.,	166 College St., Lewiston
Rand, George H.,	Livermore Falls
Randall, Ray N.,	19 Sabattus St., Lewiston
Renwick, Ward J.,	102 Goff St., Auburn
Rock, Daniel A.,	477 Main St., Lewiston
Rowe, Gunthner H.,	Livermore Falls
Roy, Leopold O.,	54 Pine St., Lewiston
Russell, Blinn W.,	98 Pine St., Lewiston
Russell, Daniel F. D.,	Leeds
Schneider, George A.,	198 Lisbon St., Lewiston
Spear, William,	Lisbon Falls
Steele, Charles W.,	1 Wakefield St., Lewiston
Sweatt, Linwood A.,	48 Drummond St., Auburn
Thomas, Camp C.,	Greene
Tibbetts, Otis B.,	33 Court St., Auburn
Tousignant, Camille,	111 Pine St., Lewiston
Twaddle, Gard W.,	57 Goff St., Auburn
Viles, Wallace E.,	Turner
Webber, Wedgwood P.,	376 Main St., Lewiston
Williams, James A.,	Mechanic Falls

HONORARY MEMBERS

Plummer, Albert W.,	Lisbon Falls
Webber, Wallace E.,	297 Main St., Lewiston

MEMBER IN MILITARY SERVICE

Barney, Maurice O.,	38 Granite St., Nashua, N. H.

AROOSTOOK COUNTY

MEMBERS

Albert, Armand,	Van Buren
Albert, Joseph L.,	Fort Kent
Albert, Louis N.,	Van Buren
Ascher, David S.,	Patten
Berrie, Lloyd H.,	Caribou
Boone, Storer W.,	Presque Isle
Burr, Charles G.,	Houlton
Carter, Loren F.,	Presque Isle
Damon, Albert H.,	Limestone
Doble, Eugene H.,	Presque Isle
Donahue, Clement L.,	Caribou
Donahue, Gerald H.,	Presque Isle
Donovan, Joseph A.,	Houlton
Ebbett, Penry L. B.,	Houlton
Faucher, Francois J.,	Grand Isle
Gagnon, Bernard,	Houlton
Gormley, Eugene G.,	Houlton
Griffiths, Eugene B.,	Presque Isle
Grow, William B.,	Presque Isle
Harvey, Thomas G.,	Fort Fairfield
Hogan, Chester,	Houlton
Huggard, Leslie H.,	Limestone
Kimball, Herrick C.,	Fort Fairfield
Kirk, William V.,	Eagle Lake
Labbe, Onil B.,	Van Buren

LaPorte, Paul C.,	Edmundston, N. B.
Larrabee, Fay F.,	Washburn
Levesque, Romeo,	Frenchville
Madigan, John B.,	Houlton
Merrick, John R.,	Caribou
Page, Rosario A.,	Caribou
Proctor, Ray A.,	Caribou
Reynolds, Arthur P.,	Presque Isle
Savage, Richard L.,	Fort Kent
Somerville, Robert B.,	Presque Isle
Somerville, Wallace B.,	Mars Hill
Swett, Clyde I.,	Island Falls
Toussaint, Leonid G.,	Fort Kent
Webber, John R.,	Houlton

HONORARY MEMBERS

Dobson, Lindley,	Presque Isle
Sincock, Wiley E.,	Caribou

CUMBERLAND COUNTY

MEMBERS

Applin, Hilton H.,	129 Main St., Brunswick
Asali, Louis A.,	29 Deering St., Portland
Babalian, Leon,	32 Deering St., Portland
Barker, Nathaniel B. T.,	Yarmouth
Beach, S. Judd,	704 Congress St., Portland
Beck, Henry W.,	Gray
Bergmann, Jerome W.,	131 State St., Portland
Bickmore, Harold V.,	723 Congress St., Portland
Bishoffberger, John M.,	Naples
Bishop, Lloyd W.,	188 State St., Portland
Blaisdell, Elton R.,	12 Deering St., Portland
Bramhall, Theodore C.,	704 Congress St., Portland
Branson, Sidney R.,	So. Windham
Broggi, Frank S.,	18 Neal St., Portland
Brown, Luther A.,	13 Deering St., Portland
Brown, Stephen S.,	22 Arsenal St., Portland
Burrage, Thomas J.,	142 High St., Portland
Burns, Robert,	Windham
Cappello, Joseph,	144 Spring St., Portland
Carmichael, Frank E.,	72 Deering St., Portland
Casey, William L.,	131 State St., Portland
Center, Ervin A.,	Steep Falls
Christensen, Harry E.,	29 Deering St., Portland
Clarke, Chester L.,	10 Congress Square, Portland
Clough, Dexter J.,	41 Carleton St., Portland
Conneen, Lawrence W.,	131 State St., Portland
Cragin, Charles L.,	831 Congress St., Portland
Cummings, George O.,	47 Deering St., Portland
Curtis, Harry L.,	142 High St., Portland
Daniels, Donald H.,	73 Deering St., Portland
Darche, Albert	782 Main St., Westbrook
Davidson, David,	45 Deering St., Portland
Davidson, Gisela K.,	45 Deering St., Portland
Davis, Harry E.,	169 State St., Portland
Davis, Paul V.,	Bridgton
Derry, George H., Jr.,	756 Congress St., Portland
Dionne, Maurice J.,	Brunswick
Dooley, Francis M.,	53 Deering St., Portland
Dore, Kenneth E.,	Fryeburg
Dorsey, Frank D.,	52 Deering St., Portland
Douphinett, Otis J.,	763 Congress St., Portland
Drake, Eugene H.,	58 Deering St., Portland
Drummond, Joseph B.,	10 Ship Channel Rd., So. Portland
Dunham, Carl E.,	201 State St., Portland
Dyer, Henry L.,	27 Green Sq., Berlin, N. H.
Dyhrberg, Norman,	331 Main St., Cumberland Mills
Emery, Harry S.,	721 Stevens Ave., Portland
Everett, Harold J.,	308 Danforth St., Portland
Fagone, Francis A.,	312 Congress St., Portland
Ferguson, Franklin A.,	9 Deering St., Portland
Ferguson, Franklin F.,	22 Arsenal St., Portland
Fickett, Jerome P.,	Naples
Files, Ernest W.,	201 State St., Portland
Finks, Henry B.,	73 Deering St., Portland
Fisher, Stanwood E.,	388 Spring St., Portland
Foster, Albert D.,	Bay Shore Drive, Falmouth Foreside
Foster, Thomas A.,	131 State St., Portland
Freeman, William E.,	Yarmouth
Geer, Charles R.,	690 Congress St., Portland
Geer, George I., Jr.,	690 Congress St., Portland
Gehring, Edwin W.,	131 State St., Portland
Getchell, Ralph A.,	690 Congress St., Portland
Geyerhahn, George,	47 Deering St., Portland
Glassmire, Charles R.,	45 Deering St., Portland
Goduti, Richard J.,	704 Congress St., Portland
Good, Philip G.,	131 State St., Portland
Gordon, Charles H.,	46 Deering St., Portland
Gould, Arthur L.,	Freeport
Greco, Edward A.,	12 Pine St., Portland
Hall, Earl S.,	696 Congress St., Portland
Ham, Joseph G.,	690 Congress St., Portland
Hamel, John R.,	50 Deering St., Portland
Hanlon, Francis W.,	46 Deering St., Portland
Hanson, Henry W., Jr.,	Cumberland Center
Haskell, Alfred W.,	142 High St., Portland
Hawkes, Richard S.,	47 Deering St., Portland
Heifetz, Ralph,	757 Congress St., Portland
Hills, Louis L.,	816 Main St., Westbrook
Holt, C. Lawrence,	178 Bay State Rd., Boston, Mass.
Holt, William,	14 Deering St., Portland
Huntress, Roderick L.,	10 Congress Sq., Portland
Ives, Howard R.,	690 Congress St., Portland
Jackson, Calvin S.,	312 Congress St., Portland
Jamieson, James G. S.,	82 High St., Portland
Johnson, Albert C.,	45 Deering St., Portland
Johnson, Gordon N.,	Houlton
Johnson, Henry P.,	32 Deering St. Portland
Johnson Oscar R.	18 Deering St., Portland
Konecki, John T.,	821 Washington Ave., Portland
Kupelian, Nessib S.,	Pownal
Lamb, Henry W.,	131 State St., Portland
Lappin, John J.,	171 State St., Portland
Laughlin, K. Alexander,	201 State St., Portland
Leighton, Adam P.,	192 State St., Portland
Leighton, Wilbur E.,	192 State St., Portland
Little, Albion H.,	692 Congress St., Portland
Logan, G. E. C.,	144 State St., Portland
Lombard, Reginald T.,	793 Main St., So. Portland
Lorimer, Robert V.,	201 State St., Portland
Lothrop, Eaton S.,	690 Congress St., Portland
Love, Robert B.,	Gorham
Lovely, David K.,	73 Deering St., Portland
Macdonald, H. Eugene,	690 Congress St., Portland
Maltby, George F.,	29 Deering St., Portland
Marshall, Donald F.,	142 High St., Portland
Marston, Paul C.,	Kezar Falls
Martin, Ralf S.,	58 Deering St., Portland
Martin, Thomas A.,	131 State St., Portland
McAdams, William R.,	723 Congress St., Portland
McCann, Eugene C.,	214 Deering St., Portland
McCrum, Philip H.,	188 State St., Portland
McDermott, Leo J.,	151 Vaughan St., Portland
McLean, E. Allan,	29 Deering St., Portland
McManamy, Eugene P.,	39 Deering St., Portland
Melnick, Jacob,	333 Congress St., Portland
Miller, Thor,	752 Main St., Westbrook
Monkhouse, William A.,	131 State St., Portland
Moore, Roland B.,	201 State St., Portland
Morrison, Alvin A.,	57 Deering St., Portland
Morrison, James B.,	582 Main St., Westbrook
Moulton, Albert W.,	180 State St., Portland
Moulton, Albert W., Jr.,	180 State St., Portland
O'Donnell, Eugene E.,	32 Deering St., Portland
Ottum, Alvin E.,	31 Deering St., Portland
Parker, James M.,	31 Deering St., Portland
Patterson, James,	614 Highland Ave., So. Portland
Peaslee, C. Capen, Jr.,	339 Woodford St., Portland
Peters, Clinton N.,	10 Congress Sq., Portland
Pingree, Harold A.,	131 State St., Portland
Polisner, Saul R.,	188 State St., Portland
Porter, Joseph E.,	22 Arsenal St., Portland
Richardson, Clyde E.,	Brunswick
Ridlon, Joseph R.,	20 South St., Gorham

Robinson, Carl M.,	31 Deering St., Portland
Rowe, Daniel M.,	757 Congress St., Portland
Santoro, Domenico A.,	756 Congress St., Portland
Sawyer, Samuel G.,	Cornish
Schwartz, Carol,	Kings County Hospital, Brooklyn, N. Y.
Scolten, Adrian H.,	32 Deering St., Portland
Shanahan, William H.,	306 Congress St., Portland
Skillin, Waldo T.,	87a Ocean St., So. Portland
Smith, Frank A.,	343 Main St., Westbrook
Smith, Kenneth E.,	73 Deering St., Portland
Spencer, Jack,	31 Deering St., Portland
Stetson, Elbridge G. A.,	Brunswick
Stevens, Theodore M.,	32 Deering St., Portland
Stuart, Albert F.,	23 Noyes St., Portland
Sulkowitch, Hirsh,	105 Falmouth St., Portland
Szanton, Victor L.,	Jackman Station
Tabachnick, Henry M.,	110 Park Ave., Portland
Thaxter, Langdon T.,	22 Arsenal St., Portland
Thompson, Philip P.,	704 Congress St., Portland
Tibbetts, George A.,	519 Cumberland Ave., Portland
Tobie, Walter E.,	3 Deering St., Portland
Tougas, Raymond,	Brunswick
Ulpts, Reynold G. E.,	83 West St., Portland
Upham, Roscoe C.,	15 Crescent St., Biddeford
Walker, Maribel H.,	Cape Cottage
Ward, John V.,	131 State St., Portland
Webb, Harold R.,	Brunswick
Webber, Isaac M.,	29 Deering St., Portland
Webber, M. Carroll,	735 Stevens Ave., Portland
Webster, Fred P.,	10 Congress Sq., Portland
Weeks, DeForest,	158 Pleasant Ave., Portland
Welch, Francis J.,	44 Deering St., Portland
Wellington, J. Foster,	655 Congress St., Portland
Wescott, Clement P.,	Windham Hill
Whitney, Harlan R.,	655 Congress St., Portland
Whittier, Alice A. S.,	143 Neal St., Portland
Wight, Donald G.,	30 Mitchell Rd., So. Portland
Williams, Ralph E.,	Freeport
Wilson, Clement S.,	Brunswick
Witte, Max E., Jr.,	29 Deering St., Portland
Woodman, Arthur B.,	Falmouth Foreside
Zolov, Benjamin,	296 Congress St., Portland

HONORARY MEMBERS

Bradford, William H.,	133 Coyle St., Portland
Brock, Henry H.,	Alfred
Howard, Harvey,	Freeport
Pepper, John L.,	960 Sawyer St., So. Portland
Robinson, Edward F.,	Falmouth
Tetreau, Thomas,	44 Monument St., Portland
Wheet, Frederick E.,	773 Main St., Westbrook

MEMBERS IN MILITARY SERVICE

Fogg, C. Eugene,	Walter Reed Hospital, Washington, D. C.
Hynes, Edward A.,	So. Portland
Thompson, Milton S.,	Portland

FRANKLIN COUNTY

MEMBERS

Brinkman, Harry,	Farmington
Chase, Philip,	Wilton
Colley, Maynard B.,	Wilton
Croteau, J. Thomas	Chisholm
Floyd, Albion E.,	New Sharon
Floyd, Paul,	Farmington
Kyes, Preston,	North Jay
LaTourette, Kenneth A.,	Farmington
Moulton, John H.,	Rangeley
Pratt, George L.,	Farmington
Reed, James W.,	Farmington
Thompson, Cecil F.,	Phillips
Weymouth, Currier C.,	Farmington
Winslow, Donald J.,	Rangeley
Zikel, Herbert M.,	Wilton

HONORARY MEMBER

White, Verdeil O.,	East Dixfield

HANCOCK COUNTY

MEMBERS

Babcock, Harold S.,	Castine
Bliss, Raymond V. N.,	Blue Hill
Cameron, Dwight,	Northeast Harbor
Clarke, Raymond W.,	Ellsworth
Coffin, Ernest L.,	Northeast Harbor
Coffin, Silas A.,	Bar Harbor
Crowe, James H.,	Ellsworth
Gray, Philip L.,	So. Brooksville
Hagopian, Leon G.,	Southwest Harbor
Knowlton, Charles C.,	Ellsworth
Kopfmann, Harry,	Deer Isle
Larrabee, Charles F.,	Bar Harbor
Millstein, Hyman,	Southwest Harbor
Morrison, Charles C., Jr.,	Bar Harbor
O'Meara, E. S.,	Ellsworth
Parcher, George,	Ellsworth
Sumner, Charles M.,	West Sullivan
Thegan, Edward,	Bucksport
Torrey, Marcus A.,	Ellsworth
Trowbridge, Mason,	Ellsworth
Weymouth, Raymond E.,	Bar Harbor
Wilbur, Herbert T., Jr.,	Southwest Harbor

HONORARY MEMBERS

Holt, Hiram Allen,	Winter Harbor
Little, Clarence C.,	Bar Harbor

KENNEBEC COUNTY

MEMBERS

Abbott, Henry W.,	116 Main St., Waterville
Bauman, Clair S.,	177 Main St., Waterville
Bisson, Napoleon,	29 Common St., Waterville
Bourassa, Harvey J.,	50 Main St., Waterville
Brann, Henry A.,	318 Water St., Augusta
Breard, Joseph A.,	15 Summer St., Waterville
Bristol, Leverett D.,	State House, Augusta
Bull, Frank B.,	72 Church St., Gardiner
Carter, Frederick R.,	43 Sylvan Rd., So. Portland
Cates, Samuel C.,	East Vassalboro
Chasse, Richard L.,	173 Main St, Waterville
Cobb, William O.,	47 Brunswick Ave., Gardiner
Cook, Aaron,	44 Main St., Waterville
Coombs, George A.,	283 Water St., Augusta
Cromwell, Charles D.,	Central Maine Sanatorium, Fairfield
Cyr, Gerald A.,	50 Main St., Waterville
Dore, Clarence E.,	Waterville
Dunn, Robert H.,	Veterans' Adm., Togus
Elkins, Harry,	Augusta State Hospital, Augusta
Farrell, Chalmers G.,	2 Church St., Gardiner
Fay, Thomas F.,	286 Water St., Augusta
Fisher, Samson,	Oakland
Flanders, Merton N.,	177 Main St., Waterville
Giddings, Paul D.,	25 Gage St., Augusta
Giesen, Joseph H.,	Waterville
Gingras, Adolphe J.,	99 Water St., Augusta
Gingras, Napoleon J.,	105 Water St., Augusta
Goodrich, Blynn O.,	165 Main St., Waterville
Gousse, William L.,	Fairfield
Guite, L. Armand,	27 Main St., Waterville
Hardy, Theodore E., Jr.,	65 Temple St., Waterville
Harlow, Edwin W.,	177 Main St., Waterville
Harris, Ralph N.,	7 W. Crescent St., Augusta
Herring, Leon D.,	Winthrop
Hill, Frederick T.,	177 Main St., Waterville
Hill, Howard F.,	177 Main St., Waterville
Hirschberger, Celia,	44 Main St., Waterville
Hurd, Allan C.,	72 Church St., Gardiner
Jackson, Elmer H.,	304 Water St., Augusta
Jump, Clarence E.,	Veterans' Adm., Tuscaloosa, Ala.
Kagan, Samuel H.,	283 Water St., Augusta
Kenney, Clarence J.,	Veterans' Adm., Wadsworth, Kansas
Lambert, Greenleaf H.,	20 Canton Rd., Shanghai, China
Langer, Ella,	State House, Augusta

Libby, Ara B.,	295 Water St., Gardiner
Libby, Harold E.,	Water St., Gardiner
Lubell, Moses F.,	50 Roosevelt Ave., Waterville
Manuel, Meyer,	Veterans' Adm., Togus
Marquardt, Matthias,	Augusta State Hospital, Augusta
Mazzola, Stephen,	R. F. D. 2, Augusta
McCoy, Thomas C.,	90 Main St., Waterville
McKay, Roland L.,	284 Water St., Augusta
McLaughlin, Clarence R.,	345 Water St., Gardiner
McLaughlin, Ivan E.,	345 Water St., Gardiner
McQuillan, A. H.,	177 Main St., Waterville
McWethy, Wilson H.,	284 Water St., Augusta
Merrill, Percy S.,	82 Elm St., Waterville
Metzgar, John G.,	175 Water St., Augusta
Michaud, Joseph H. C.,	76 Main St., Waterville
Milliken, Howard H.,	105 Second St., Hallowell
Mitchell, Roscoe L.,	111 Western Ave., Augusta
Moore, Arnold W.,	756 Congress St., Portland
Morrell, Arch H.,	State House, Augusta
Murphy, Norman B.,	77 Winthrop St., Augusta
Newcomb, Charles H.,	Clinton
Newman, Benjamin,	Veterans' Adm., Togus
O'Connor, William J.,	341 Water St., Augusta
Odiorne, Joseph E.,	Cooper's Mills
Parizo, Harry L.,	2 Silver St., Waterville
Piper, John O.,	177 Main St., Waterville
Pomerleau, Ovide F.,	Professional Bldg., Waterville
Pomerleau, Rodolphe J. F.,	Professional Bldg., Waterville
Poulin, James E.,	177 Main St., Waterville
Priest, Maurice A.,	283 Water St., Augusta
Provost, Helen C.,	48 Green St., Augusta
Provost, Pierre E.,	48 Green St., Augusta
Reynolds, John F.,	Waterville
Reynolds, Ralph L.,	101 Main St., Waterville
Risley, Edward H.,	27 College Ave., Waterville
Sanders, Stephen W.,	Winthrop
Schmidt, Lorrimer M.,	Veterans' Adm., Togus
Sewall, Kenneth W.,	173 Main St., Waterville
Shelton, M. Tieche,	61 Winthrop St., Augusta
Shippee, James N.,	No. Monmouth
Simpson, Margaret,	Augusta
Sleeper, Francis H.,	State Hospital, Augusta
Small, Harold E.,	31 Grove St., Augusta
Sommerfeld, Kurt A.,	6 Main Ave., Gardiner
Staciva, Stanley J.,	99 Sewall St., Augusta
Stubbs, Richard H.,	133 State St., Augusta
Towne, Charles E.,	135 Main St., Waterville
Towne, John G.,	135 Main St., Waterville
Trask, Burton W.,	Veterans' Adm., Togus
Tyson, Forrest C.,	R. F. D. 5, Augusta
Ventimiglia, William A.,	477 Congress St., Portland
Wadsworth, George L.,	Veterans' Adm., Togus
Williams, Edmund P.,	Oakland
Wilson, Robert W.,	Veterans' Adm., Togus
Young, William J.,	92 Wood St., Lewiston

HONORARY MEMBER

Campbell, George R.,	175 Water St., Augusta
Turner, Oliver W.,	Boothbay Harbor

KNOX COUNTY

MEMBERS

Allen, Robert L.,	38 Union St., Rockland
Apollonio, Howard L.,	Camden
Brown, Freeman F.,	5 Beech St., Rockland
Brown, Freeman F., Jr.,	15 Maple St., Rockland
Burgess, Lyman C.,	Camden
Campbell, Fred G.,	Warren
Dennison, Frederick C.,	Thomaston
Earle, Ralph P.,	Vinalhaven
Frohock, Horatio W.,	10 Summer St., Rockland
Green, Archibald F.,	60 Elm St., Camden
Hall, Walter D.,	407 Main St., Rockland
Jameson, C. Harold,	465 Main St., Rockland
Jones, Paul A.,	Union
Lawry, Oram R., Jr.,	27 Oak St., Rockland
Mann, David V.,	Camden
Miller, Herbert L.,	Camden
Millington, Paul A.,	Camden
North, Charles D.,	38 Union St., Rockland
Platt, Anna,	Friendship
Shields, Victor H.,	North Haven
Soule, Gilmore W.,	465 Main St., Rockland
Tounge, Harry G.,	Camden
Tweedie, Hedley V.,	407 Main St., Rockland
Wasgatt, Wesley N.,	7 Talbot Ave., Rockland
Weisman, Herman J.,	76 Limerock St., Rockland

HONORARY MEMBER

Coombs, George H.,	Waldoboro

LINCOLN-SAGADAHOC COUNTY

MEMBERS

Barrows, H. C.,	Boothbay Harbor
Belknap, Robert W.,	Damariscotta
Bousfield, Cyril E.,	Woolwich
Day, DeForest S.,	Wiscasset
Doble, Miriam,	Bath
Dougherty, John,	112 Front St., Bath
Fuller, Edwin M.,	119 Front St., Bath
Fuller, Edwin M., Jr.,	108 Front St., Bath
Gregory, Philip O.,	Boothbay Harbor
Hamilton, Virginia C.,	900 Washington St., Bath
Hawkins, Donald B.,	South Bristol
Kershner, Warren E.,	119 Front St., Bath
Laughlin, James W.,	Newcastle
Lenfest, Stanley R.,	Waldoboro
Morin, Harry F.,	72 Front St., Bath
Nichols, Arthur A.,	Wiscasset
Parsons, Neil L.,	Damariscotta
Pratt, Edwin F.,	7 Main St., Richmond
Proctor, Thomas E.,	Boothbay Harbor
Stott, Ardenne A.,	117 Front St., Bath
Smith, Jacob,	118 Front St., Bath
Smith, Joseph I.,	118 Front St., Bath
Stetson, Rufus E.,	Damariscotta
Sylvester, Philip H.,	Damariscotta
Wilson, Harry M.,	Middle St., Bath
Winchenbach, Francis A.,	Washington St., Bath

MEMBER IN MILITARY SERVICE

Dalrymple, Sidney C.,	Georgetown

OXFORD COUNTY

MEMBERS

Adams, Lester,	Western Maine Sanatorium, Greenwood Mt.
Aucoin, Pierre B.,	77 Rumford Ave., Rumford
Boynton, Willard H.,	Bethel
Cohen, Leon,	Fryeburg
Defoe, Garfield G.,	Dixfield
Dixon, Walter G.,	Norway
Eastman, Charles W.,	Livermore Falls
Elsemore, Dexter E.,	Dixfield
Greene, John A.,	96 Congress St., Rumford
Holin, Sabina	Greenwood Mt.
Howard, Henry M.,	105 Franklin St., Rumford
Hubbard, Roswell E.,	Waterford
Kay, Edwin,	671 Main St., Lewiston
Leslie, Frank E.,	Andover
MacDougall, James A.,	303 Penobscot St., Rumford
McCarty, Eugene M.,	82 Main Ave., Rumford
McCormack, Roland L.,	Norway
Moore, Beryl M.,	Oxford
Nelson, Chelsey W.,	Norway
Noyes, Harriett L.,	114 Congress St., Rumford
Oestrich, Alfred,	1061 St. Nicolas Ave., New York 32, N. Y.
Pearson, Henry,	Brownfield
Reeves, Edward L.,	South Paris
Reeves, Helene M.,	South Paris
Rowe, William T.,	250 Penobscot St., Rumford
Royal, Albert P.,	82 Main Ave., Rumford

Stanwood, Harold W.,	5 Franklin St., Rumford
Stewart, Delbert M.,	So. Paris
Tibbetts, Raymond R.,	Bethel
Villa, Joseph A.,	17 Main St., South Paris

HONORARY MEMBER

Sturtevant, James S.,	Dixfield

MEMBERS IN MILITARY SERVICE

Corliss, Leland M.,	West Paris
Daniels, S. David,	1435 South Fairfax Ave., Los Angeles, Cal.

PENOBSCOT COUNTY

MEMBERS

Adams, Asa C.,	Main St., Orono
Adams, Winford C.,	142 No. Main St., Brewer
Ames, Forrest B.,	489 State St., Bangor
Barrett, Robert J., Jr.,	Bangor
Blaisdell, Carl E.,	47 Broadway, Bangor
Blaisdell, William B.,	11 Ohio St., Bangor
BoDine, Charles E.,	207 State St., Bangor
Bridges, Donald E.,	Winterport
Burke, Paul W.,	Newport
Butler, Harry,	77 Broadway, Bangor
Clement, James D.,	77 Essex St., Bangor
Clough, Dexter J., 2nd,	224 State St., Bangor
Clough, Herbert T., Jr.,	111 State St., Bangor
Comeau, Wilfrid J.,	48 Penobscot St., Bangor
Cornell, Robert C.,	Orono
Craig, D. Allan,	41 East 42nd St., New York 17, N. Y.
Cutler, Lawrence M.,	Bangor
Devan, Thomas A.,	325-19th Ave., N. E., St. Petersburg, Florida
Dinan, Joseph F.,	12 Fairmont Ave., Wakefield, Mass.
Dunham, Rand A.,	East Millinocket
Emerson, W. Merritt,	131 State St., Bangor
Emery, Clarence, Jr.,	92 Essex St., Bangor
Feeley, J. Robert,	3 Third St., Bangor
Fellows, Albert W.,	52 Ohio St., Bangor
Ford, Leonard H.,	217 State St., Bangor
Gumprecht, Walter R.,	116 State St., Bangor
Hall, Walter C.,	Orono
Hall, Walter L. H.,	50 N. Fourth St., Old Town
Hammond, Walter J.,	State Hospital, Bangor
Hedin, Carl J.,	State Hospital, Bangor
Herlihy, Edward L.,	159 State St., Bangor
Higgins, George I.,	Newport
Hinman, Havilah E.,	Orono
Horton, George H.,	Hermon
Houlihan, John S.,	209 State St., Bangor
Hunt, Harrison J.,	162 French St., Bangor
Knowlton, Henry C.,	47 Broadway, Bangor
Lezberg, Joseph,	116 State St., Bangor
Lieberman, Arthur N.,	27 State St., Bangor
Lippincott, Leon S.,	489 State St., Bangor
Macdonald, Donald F.,	Bangor
Maddan, Martin C.,	Old Town
Mansfield, Blanche M.,	191 State St., Bangor
Mason, Luther S.,	109 State St., Bangor
McKay, Hugh G.,	Old Town
McNamara, Wesley C.,	Lincoln
McNeil, Harry D.,	58 Hammond St., Bangor
McQuoid, Robert M.,	39 Columbia St., Bangor
Memmelaar, Joseph	South Brewer
Miragliuolo, Leonard	Bangor
Moulton, Manning C.,	150 State St., Bangor
Munce, Richard T.,	205 French St., Bangor
Osler, Jay K.,	State and Grove Sts., Bangor
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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, July, 1947 No. 7

*Recent Advances in Pediatrics**

By Edwin T. Wyman, M. D., Visiting Physician, Children's and Infants' Hospitals, Boston, Instructor in Pediatrics, Harvard Medical School

It is a pleasure to again attend one of your County medical meetings and especially to celebrate Dr. Merrill's birthday. When Mrs. Merrill asked me to give a short paper she did not give me a subject so I decided to take up a varied subject including modern forms of treatment in the prevention and treatment of diseases in infancy and childhood.

The concept of the field of pediatrics which is held by certain persons, even by some closely connected with medical circles, is a limited one. To some the practice of pediatrics is essentially infant feeding, to others management of the ills of the first two or three years of life and to still others it is the practice of preventive medicine and to a few it is simply the management of behavior disorders. It is all of these and more. Concern for the child must antidate conception and extend through the final phases of growth and the period of adolescence.

Care of the unborn child is provided by adequate supervision of the pregnant woman and obstetric care at the time of delivery is directly reflected in the welfare of the infant.

The neonatal period or the first four weeks of life is the single most important period of life and presents problems that never exist again.

Infancy or the first two years of life represent the period of most rapid growth. This is the time when the infant is completely dependent on others for all phases of his care; when he is not only more susceptible to infections and nutritional disturbances but often has a pattern of response to them, which differs from that of later years. As the age of infancy is passed and the preschool, prepuberty and adolescent ages are attained, the child assumes increasing responsibility in its own care, but intelligent and understanding pediatric supervision continues to be an important aid.

Regular antenatal visits to the physician have been a distinct factor in the reduction of both maternal and infant mortality and should be considered essential. The Rh factor may be related to disturbances in the mother as well as in the infant and ideally the Rh status of both the mother and father should be known before delivery. Given an Rh positive father and an Rh negative mother, tests for anti-Rh agglu-

* Presented before the Piscataquis County Medical Society, February 22, 1947.

tinins should be made at the seventh month of pregnancy and if they are present, tests should be made every two weeks and the question of terminating the pregnancy before term decided by the strength of the anti-Rh agglutinins. The possibility of a strong anti-Rh agglutinins and the subsequent birth of erythroblastotic infant is greatly increased after the first or second pregnancy. Although I have a patient who had her sixth child two months ago, a perfectly normal baby, until her last pregnancy she did not know her husband was Rh positive and she was Rh negative. Her blood showed no anti-Rh agglutinins.

Prematurity represents the single and most important problem of the neonatal period. During the first month of life it accounts for almost one-half the total number of deaths and more than half of those resulting from prenatal and natal causes. The smaller the infant the less are his chances of survival. However, weight of the infant at birth is not the sole factor which determines survival. Toxemia or other illnesses of the mother, the physical condition of the infant and the quality of his care beginning immediately after birth are of the greatest importance. The problems of prematurity must be approached from two broad aspects: prevention of premature birth and improvement in the care of the premature infant.

The care of a premature infant consist in part as follows:

1. On receiving word of the expected admission of a premature infant the Premature Supervisor shall:

a. Fill the Hess Bed water jacket so that the bed temperature is 95°.

b. Attach the oxygen tubes to the Hess bed and allow oxygen to flow into the bed at the rate of 2 liters per minute for *not over* 15 minutes prior to placing the baby in the bed.

c. Have sterile cotton wool wrapper in warming cabinet ready to receive baby on arrival.

d. Have suction apparatus in readiness.

On admission the normal premature infant's temperature is usually from 94 to 96°. It fluctuates for 2 or 3 days gradually reaching a level between 97 and 99° by the end of from one week to 6 weeks. Occasional drops to 95° occur and cause no concern and demand no change in the treatment unless it persists at this level. We try to let the temperature stabilize between 97 and 99°.

Give the premature infant nothing by mouth for 24 hours. If at the end of this period the infant is not in perfect condition with excellent color—cry—gag and swallowing—reflexes, delay a second 24 hours, supporting the infant by clyses. If after 48 hours the infant's condition is still cause for concern, wait a third 24-hour period supporting the infant by means of clyses and intravenous glucose administration.

As a general rule, except for vigorous infants in the 4- to 5-pound zone, all premature infants receive their first fluids and food by gavage.

The feeding interval is every 4 hours except in the case of infants below 3 pounds in weight when the interval may be every 3 or 2 hours.

The usual orders for the first introduction of fluid and food are as follows:

Begin with 1 dram of 5% glucose in normal saline; 1 hour later give 2 drams; 2 hours later, 4 drams; 4 hours later, 6 drams; 4 hours later, 1 ounce; 4 hours later, 6 drams 5% glucose in normal saline and 2 drams breast milk. Thereafter on each feeding period replace 2 drams of the glucose solution with an equal amount of breast milk until 1 ounce of breast milk is given every 4 hours. Stop feedings at once if vomiting occurs and proceed more slowly.

Breast milk is to be used whenever available.

The total calories usually given per 24 hours are as follows:

By the third day 30 to 35 calories; by the seventh day 50 to 60 calories and by the fourteenth day 60 to 70 calories.

Vitamin K, 1.0 mgs. 2 Methyl — 1, 4 — napthoquinone crystals dissolved in 2 drams water given by gavage during the first 24 hours.

Vitamin C, 25 mgs. of cevitamic acid daily beginning on the seventh day.

Vitamin D, 1 drop of drisdol daily beginning on the seventh day.

Vitamin B complex, 4 drops of White's Vitamin B Complex concentrate daily beginning on the seventh day.

Ferrous sulphate, ½ dram of Elixir of Feosol daily beginning on the fourteenth day, in-

creasing the amount each succeeding week by ½ dram until 2 drams are given daily.

All premature infants and all infants having been exposed to known intrauterine asphyxia or showing clinical signs of respiratory distress or atelectasis are to be placed in an atmosphere of 50% oxygen as soon after birth as possible. They are to be kept in this environment for an indefinite period until physical examination demonstrates this treatment is no longer required.

Prevention of Infection:

a. No one is to be admitted to the Nursery except in the line of duty.

b. All entering the Nursery must wear clean, long white coats or gowns.

c. All entering the Nursery must wear the approved hospital masks.

d. Hands must be washed with soap and water before handling or examining an infant.

e. All parts of examining instruments coming in contact with an infant's skin must be cleansed before another infant is examined.

f. No one with an upper respiratory infection should be admitted to the nursery.

g. All infectious patients should be removed at once from nursery.

Intracranial hemorrhage may result from trauma or asphyxia or may be a manifestation of such fetal disturbances as hemorrhage of the newborn.

Symptoms of intracranial hemorrhage may be present at birth or they may not appear for a variable period of time after delivery. When symptoms are present immediately after birth they are most likely to be those of disturbed respiratory or cardiac function. When they appear within a few hours after birth they are apt to consist of irritative phenomena such as muscular twitching or frank convulsions with or without respiratory or cardiac symptoms.

Intracranial hemorrhage should be suspected in a newborn infant in the presence of such symptoms as somnolence, pallor, cyanotic attacks, failure to suck properly, anxiety and restlessness and a high pitched cry. In the treatment rest is of paramount importance, the infant should be handled as little and as gently as possible. The infant should be kept warm, the head slightly elevated and oxygen administered freely. Sodium pheno barbital ⅛ grain may be administered intramuscularly to control convulsive movements. There is lack of agreement concerning the advisability of performing lumbar punctures. I believe the mild cases should be left alone. However, in the cases with more severe symptoms I favor spinal drainage repeated as necessary to relieve intracranial pressure and to remove accumulated blood when it is present. There does not appear to be evidence of damage or of stimulation to increased bleeding by repeated spinal drainage. In cases where a subdural hematoma is suspected subdural taps should be made and repeated as necessary if blood is obtained from the tap.

While most normal babies can be made to thrive on simple dilutions of cow's milk with the addition of various carbohydrates, one is often confronted by various mal-adjusted cases. In order to treat these cases the physician must have a wide range of food from which to choose to meet the requirements of each individual case. Dried milk, reconstructed milks, evaporated milk, condensed milk and various proprietary foods all have their place in infant feeding. In evaporated milk, for example, we have cow's milk product with changes brought about in the process of fabrication of such a nature as to render it easier of utilization by the infant's gastro-intestinal system than fresh cow's milk. It can be modified in the same way as whole milk mixtures and often serves the purpose until the baby's digestion can handle a whole cow's milk mixture. A milk formula should not be introduced until there has been ample opportunity for lactation to be established. When a formula is required the first feedings should consist of a dilute one, the concentration of which is gradually increased as tolerated. During the first few days attention is directed toward an adequate fluid intake, later, greater consideration can be given to adequate caloric intake. The infant is less likely to have regurgitation and abnormal stools if this procedure is followed. I think it is better to prescribe a formula in which the ratio of evaporated milk to water is 1 to 3 and increase it gradually to one in which the ratio is 1 to 2, starting with:

Formula No. 1. Evaporated milk, 5 ounces; water, 16 ounces; Karo corn syrup, ½ ounce (12.4 calories per ounce).

Formula No. 2. Evaporated milk, 6 ounces; water, 15 ounces; Karo corn syrup, ¾ ounce (calories, 16 per ounce) and

Formula No. 3. Evaporated milk, 7 ounces; water, 14 ounces; Karo corn syrup, 1 ounce (calories, 19 per ounce).

When cereal is given at about two months, it is best to start with any of the precooked cereals, one to two tablespoonfuls at ten in the morning and six in the afternoon with some of the formula poured over it followed by the rest of the formula. At this age it will take about a month to teach the infant to take the cereal from a spoon well. Vegetable soup, egg yolk, strained vegetables (spinach, carrots and string beans), should be started at 2½ to 3 months given at the two o'clock feeding in the afternoon together with ½ slice zwieback. Baked banana, prune pulp, apple sauce and junket can be given at about the same age. Potato, whole egg, chicken, lamb chop, and beef steak, finely choped and mixed with the vegetables, should not be given until the infant is 10 or 11 months old.

Much information has been obtained since the beginning of the present century in the control of cross infections in hospitals. In the Infants' Hospital each patient is in a cubicle six feet wide with partitions extending eight feet upward from the floor but not to the ceiling. Individual technique is practiced by all members of the medical and nursing staff; individual bath tubs, thermometers and other articles are kept in each cubicle.

The daily stay in the hospital has steadily decreased during the past five years and the mortality rate has also steadily dropped. This lowering of infant mortality is undoubtedly due in part to better understanding of the causes of many diseases and the application of new and specific forms of treatment.

The sulfonamide and antibiotics have so changed the treatment of many diseases that complications such as empyema, mastoiditis, osteomyelitis of the frontal bone, etc., are rare indeed. It has been said that patients coming to the hospital get sulfadiazine or penicillin or both as soon as they reach the front door. I think this is an exaggeration but it is a fact that they are given the drug much earlier than a few years ago.

There was a time when the bacteriology of the infection was found before specific therapy was started but it was found that time was lost, so now it seems best to take laboratory data and cultures as soon as the child is admitted and if the clinical diagnosis has been made and in cases where there seems to be an overwhelming infection, the treatment with sulfadiazine or penicillin or both is started even before a definite diagnosis is made. It is true that the infection may clear up without a definite diagnosis being made. This is not so good for the hospital record. However, in some cases it may have saved a life. In virus infection these drugs while they have no beneficial effect on the virus, combat complicating infections and in my opinion should not be excluded simply because of a low white count.

Sulfadiazine may be given to young patients unable to swallow tablets by crushing the tablets and mixing them with apple sauce, fruit juices or syrup. To older children tablets may be given with pleasantly flavored hard candy and allowed to dissolve in the mouth. The daily dosage of sulfadiazine is from 1 to 1½ grains per pound of body weight. There is a tendency now to use sulfadiazine in doses of 1 gram daily continuously summer and winter in patients having recurrent attacks of rheumatic fever, nephrosis and in some cases of respiratory infections associated with asthma, not to treat the disease but to prevent recurring infections.

Sulfonamides are indicated in severe infections due to sulfonamide-susceptible organisms. They may be indicated prophylactically in patients with rheumatic fever to reduce the incidence of hemolytic streptococcal infections, in debilitated patients or those with chronic disease twenty-four hours before and forty-eight hours after dental extractions and tonsillectomies in any operative procedure where bacteriemia may be a sequel such as the incision of a carbuncle and the like. Sulfonamides are of no value in the direct treatment of common colds, acute rheumatc fever, chorea, measles, smallpox, diphtheria, influenza, poliomyelitis and malaria.

On account of the toxicity of the drug, the history of previous sulfonamide administration

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On the Prevention of Coronary Disease

By Lloyd H. Berrie, M. D., Caribou, Maine

"It is an interesting paradox that the medical profession should readily agree that a disturbance in the simplest metabolic system; that of the carbohydrates, could be responsible for a generalized disease, while it is largely unaware or critical of the claim that a disturbance in the metabolism of one of the most complex substances met with in the human body — cholesterol — could produce a generalized disease."[1]

That interesting statement by Timothy Leary,[2] carries immediate weight and significance among those who are aware of the many years of painstaking pathological research and factual knowledge that is behind it.

Arteriosclerosis signifies a chronic non-infectious lesion of the arteries due to metabolic disfunction. Pathologically there are three types:

1) Atherosclerosis. This is the most important one with regards to morbidity and mortality. It is distinguished from the other types by the presence of fatty material in the lesion. The lesion starts in the subendothelial layers of the intima.

2) Arteriolosclerosis. This is not a gross lesion. Histologically the basement membrane is thickened and hyalinized with subsequent muscle degeneration.

3) Monckeberg's sclerosis. It occurs in the larger arteries. It is characterized by medial layer necrosis and calcification. This is the so-called "pipe stem" sclerosis.

In this abstract we are concerned with atherosclerosis and its role in the development of coronary heart disease. The pertinent evidence is that obtained from many cases of sudden death from coronary sclerosis, uncomplicated by the secondary inflammatory changes met with in coronary lesions that are so often seen in hospitalized cases of long standing.

Leary's studies confirmed the belief that cholesterol esters in the coronary lesions were not casual or secondary agents.[3] The Russian school had long ago produced atherosclerosis in the rabbit by using egg-yolk diets that are rich in cholesterol. Then Anitschlow and Chalatow reproduced atherosclerosis by feeding cholesterol in oil. Since advanced human atherosclerotic lesions are manifestly the result of years of development, an effort to reproduce human lesions, pathologically identical, was undertaken by permitting test rabbits to live for years, some being fed cholesterol at intervals. The results permitted a pathological comparison with human lesions of advanced coronary disease. It was clearly shown that the lesions were essentially identical, within the limits of experimental reproduction.

A second study dealt with the aortic lesions of human atherosclerosis. Careful pathological study of this disease in hundreds of cases brought out evidence that the development of the lesion followed a definite order of succession, *and the continuing evidence in all active cases was the presence of lipoid cells carrying cholesterol esters.*

Incident to this discovery was the fact that in the aortic lesion of youth the excess cholesterol was removed from the lipoid cells through the action of fibroblastic cells. The power to remove excess cholesterol and thus obliterate lesions in their early stages is limited largely to youth, but persists in the ascending aorta into old age.

Cholesterol is present in every animal cell but usually in a combined non-visible form. In ester form it is fluid and visible and the drops are doubly refractive. Their appearance is as distinctive as stained turbicle bacilli. Visible esters occur normally in the adrenal cortex, sometimes in the interstitial cells of the testicle and sometimes in the corpora lutea. Visible ester cholesterol in other sites is excess cholesterol. Its presence is associated with disease.

Progression of the lesion of atherosclerosis from the primary invasion of the arterial intima is due to the irritant action of the cholesterol esters. This leads to fibrosis which with necrosis and sometimes calcification sets the stage for coronary thrombosis.

Various factors influence the development of atherosclerosis. Cholesterol metabolism appears to be controlled by thyroid function.[4, 5] Age

(time plus thyroid deterioration) is responsible for the frequency of the disease in older persons, but age itself is not a probable cause. There are many coronary deaths showing advanced atherosclerotic changes where the stigmata of age is absent. Sex is a factor. Women apparently have a better cholesterol metabolism than men. Stress is an important factor in the localization and spread of the lesion.

The relation of alcohol ingestion to the disease is suggestive. The chronic alcoholic who comes to autopsy rarely demonstrates the lesion. Regardless of the moral factors involved that fact remains.

The prevention of coronary heart disease seems to concern itself with the elimination of the excessive ingestion of animal fats, and of undue emotional stress. Its high incidence among the medical profession is well known and in the light of the foregoing may perhaps be rationalized. It is easy to conceive the presence of undue emotional stress on the vascular tree of the majority of physicians whose lives are in routine association with the environment of tragedy. And, moreover, physicians are able to, and do, partake of diets that are a delight to the taste buds and olfactory organs. Animal fats, unfortunately, contain these odorous delights and gustatory gems that are embodied in "good cooking." This leads to over-indulgence.

"The cardiologist and the clinicians are so obsessed with the electrocardiograph, which only becomes positive in advanced coronary disease, that they haven't time to think of the disease—atherosclerosis of the coronaries—and its cause.

"The cholesterol ester crystals that cause the disease are just as tangible as the turbicle bacillus and just as ugly. Some day we will know how to cure the disease. We can at least prevent it now.

"Vegetable fats contain sterols, just as animal fats do, but the vegetable sterols are not absorbed through the intestinal mucosa. So vegetable oils and fats can be substituted for animal fats—vegetable oleomargarine for butter, vegetable oils for cooking, etc. If the diet excludes animal fats including lard, or cuts down the amount ingested to the minimum, there is evidence that atherosclerosis can be prevented."[6]

"The consensus is that plant sterols are probably not absorbed from the intestine, except in the case of irradiated sterols, such as ergosterol and dehydrotachysterol. Although, as you state, there is some contradictory experimental evidence, this is certainly inconspicuous in the face of the more abundant evidence expressed above."[7]

In conclusion, the evidence is factual that at least one tangible factor in the etiology of coronary atherosclerosis is cholesterol ester crystal deposits in the subendothelial layers of the intima. Injestion of animal fats beyond the metabolic quotient of the individual predisposes to these deposits in the ascending aorta. Thyroid activity appears to play some part in the process.

Coronary thrombosis occurs in preponderence among the emotionally tense class or individual. This class in general is a good provider. Their diets are apt to be rich in animal fats.

A diet poor in animal fat, and the substitution of vegetable fats in the diet of the coronary heart disease suspect is rational. There is evidence that the pathology of artherosclerosis can be arrested or reversed by such procedure.

Small doses of alcohol following fatty meals may act in some way toward the prevention of the coronary lesion of atherosclerosis.

Nervous tension and repeated emotional episodes in daily life cause repeated peaking of blood pressure with resultant wear and tear on the vascular tree, among other things. Good mental hygiene, with the accompanying ability to relax frequently from nervous tension, must play an important part as well in the prevention of coronary heart disease.

Bibliography

1) Leary, Timothy, M. D., Sc. D. Excess Cholesterol as a Pathogenic Agent. Read at the William Harvey Society, in Boston, Mass., Sept. 16, 1943.
2) Leary, Timothy. Professor Emeritus of Pathology and Bacteriology, Tufts Medical School, and Medical Examiner, Suffolk County South, Boston, Mass.
3) Leary, Timothy. Atherosclerosis. *Archives of Pathology,* April, 1946, Vol. 21, pp. 419-458.
4) Weinhouse, Sidney. Blood Cholesterol. *Arch. Path.,* 35 :438-500, March, 1943.
5) Paindexter, Chas. D., Bruger, Maurice. Cholesterol content of the blood in Heart Disease. *Archives of Internal Medicine,* May, 1938, Vol. 61, pp. 714-719.
6) Leary, Tomithy. Personal communication.

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Simple Tests for Sugar and Acetone in the Urine

Melvin Bacon, M. D., Sanford, Maine

Recently two simple urine tests have been introduced. The "Galatest" is for sugar in the urine while the second is for the detection of acetone in the urine. The simplicity and rapidity with which they may be done make them valuable laboratory procedures in the office or hospital. According to Blotner,[1] the "Galatest" has been used routinely at the Boston Induction Center among approximately 70,000 selectees for the detection of sugar in the urine. Because of the ease with which these tests are done, and because of the satisfactory results obtained, it appeared of interest to report these tests.

The Galatest for Glycosuria

The "Galatest" for glycosuria is performed very simply. The active ingredients of the powder used in this test are sodium hydroxide and bismuth oxychloride. A drop of urine is deposited on a little "Galatest" powder placed on a piece of white paper and covering an area about ¼ inch in diameter. If sugar is present the powder will turn grey or black, immediately within thirty seconds, depending on the amount of sugar present. If no sugar is present, the powder will remain white or take on the color of urine. Any other color which appears is not due to a reducing sugar and is of no clinical significance.

In a number of cases, I have found urine tests which gave a negative qualitative Benedict's test yet gave a positive "Galatest" showing 1 + sugar. When the blood sugar was taken it was found to be elevated. These blood sugar levels were high enough to warrant a diagnosis of diabetes mellitus.

The following case illustrates such an example. Mr. P. F., age 53, was first seen for coughing, shortness of breath, and some precordial pain. These symptoms had been present for the past three or four years but had been increasing in severity. The past and family history were non-contributory. He drank large amounts of fluid, had a large appetite, and passed much urine. The general physical examination was negative. His height was 66 inches and weight 155 pounds. The blood pressure was 110/70. On routine urine examination, he was found to have a 1 + sugar by the "Galatest" while the Benedict's test was negative. A blood sugar taken at this time was found to be 208 mg %. The Hinton test was negative. The blood showed no anemia. Electrocardiograms—4 leads—showed a flat T1 and low QRS1. An X-ray of the chest was negative. The diagnosis appeared to be coronary disease and diabetes mellitus. It is known that coronary disease occurs more frequently in diabetics than in other individuals.

I teach my diabetics to test their urine with the "Galatest" and find they are more likely to test their urine for glycosuria more carefully with this method than with the Benedict's. The apparent reason for this is that it requires less effort to perform and is a convenient method to use when travelling or away from home.

The advantages of the "Galatest" are several. In the first place it is quite accurate, because faulty technique is eliminated due to its easy and simple technique. This simplicity obviates the need of boiling or laboratory equipment. In addition, the speed with which it may be done makes it of value. The reaction takes place in about 30 seconds. Large amounts of albumin, creatinine, uric acid or urates do not interfere with this reaction. It is economical to use. Inasmuch as it takes little time to perform, it is especially valuable where large scale examinations are done. Several hundreds can be done in a morning.

The Acetone Test

The acetone test is likewise easily and rapidly performed. It is of value because its presence may indicate acidosis which may occur in uncontrolled diabetes.

The powder for this test is composed of sodium carbonate, ammonium sulphate and sodium nitroprusside in anhydrous form. A little of the powder is deposited on paper or any dry

Continued on page 185

Clinico-Pathological Exercise

Case Presented at St. Mary's Hospital, Lewiston, Maine

Edited by Joseph E. Porter, M. D., Portland

This is the case of a 68-year-old unmarried female, admitted to this hospital complaining of pain in the left side of the abdomen and lumbar region for the past 3 months.

Family history: Mother had arthritis and is said to have died of acute indigestion. Father died of old age. One sister died of pneumonia and dropsy.

Past history: She had whooping cough, measles, and influenza many years ago. A tumor of the right breast was treated by "electricity" 24 years ago. She had been subject to frequent sore throats. Her menses began at age 11, and for a time she had dysmenorrhea; otherwise there was nothing remarkable about her menstrual history, and her periods stopped suddenly at age 50. For the past few years she had had what she described as "rheumatism."

Present illness: For the past 3 months she has slept poorly, awakening early in the morning, and has usually been fatigued on arising. During this time her weight has gone from 165 lbs. to 125 lbs. and she has been forced to give up her work. Appetite is poor; she has flatulence and is frequently nauseated; she does not vomit, but complains of bitter-tasting eructations. She has not been constipated, but there is some tendency to diarrhea. She has not noted any change in the color of her stools. For the past 3 months she has noted oliguria 4-5 times a day, and 2-3 times at night. She complains of pain in the knees; duration is not stated. This is associated occasionally with swelling and redness. The pain in the lumbar region is continuous and severe; it is located on the left side, from the level of the thigh to the breast, and not influenced by activity, fatigue, or meals.

Physical examination reveals a well-developed, poorly-nourished woman, lying quietly in bed. Eyes are normal. Teeth are in poor condition; the gums are boggy and red. Thyroid is not palpable. The top of a firm mass can be detected over each clavicle, and a similar mass the size of an egg above this on both sides. In addition, several smaller but similar nodules are present on the left side of the neck. They are firm, smooth, not adherent, and non-tender. There is visible carotid pulsation on both sides. Heart: The apex impulse is in the 5th intercostal space in mid-clavicular line; rate is 85. There is a palpable thrill at the apex, and a systolic murmur heard over the entire precordium. B. P. 142/68; another taken at a later date, 108/62. Lungs: Reported as negative. There is a a large mass on the left side of the abdomen extending downward from under the ribs, and laterally; it is smooth, firm, and moderately movable. There is a suggestion of a mass in the epigastrium, which is firm and slightly movable. Skin is dry and atrophic. Knee jerks are absent. There is positive bilateral ankle clonus, and no Babinski, Oppenheim, or Gordon. Bone conduction is present.

Laboratory examinations: Urine showed a slight trace of albumin and acetone. Specific gravity 1.019; in the sediment there were a few hyaline and coarsely granular casts, and many leukocytes. Blood: Hb. 70%, RBC. 4.1 million; cells showed slight poikilocytosis, anisocytosis and anisochromia. Her WBC. was 19,100, with 82% of the cells polynuclear leukocytes, 8% lymphocytes, and 10% enothelial cells. Platelets were increased. Non-protein nitrogen 41 mg.%; blood urea nitrogen 27 mg.%; blood uric acid 5.3 mg.%; blood sugar 111 mg.%. Phenolsulphthalein test: First hour 22%, second hour 30%. Basal metabolic rate +4%. X-ray of the abdomen showed a large tumor mass in the left side of the abdomen, reaching below the level of the iliac crest. There was in addition a mass in the pelvis throughout which there were scattered calcium deposits.

Clinical progress: She was in the hospital for 30 days. Her temperature was normal. Pulse varied between 80 and 100, except for the last 7 days, when it ranged between 100 and 102. Respirations were 20-25 until the last 7 days, when they varied between 30 and 35. On the 24th day she became delirious, and on the 29th day she was unconscious. Her pulse was poor, and she died on the following day.

Dr. Max Hirshler: Three months of past history and one month in the hospital is a fatal disease of rather short duration. Our discussion, therefore, is narrowed down to malignancies or sub-acute systemic diseases.

As far as the past history is concerned, we find a tumor of the breast which was treated by electricity 24 years ago. The physical findings do not mention any existing tumor or any scar. I think it is safe to assume that the original tumor was not malignant. The rheumatism mentioned and the present occasional redness and swelling are probably of the same origin. The general symptoms can fit in the category of severe wasting disease. There is an impressive weight-loss. The local symptoms are described as pain in the left abdomen and lumbar region radiating up and down.

On admission, the patient is already in a state of considerable weakness and shows signs of nutritional deficiency. The heart findings are more of mitral regurgitation than of the pericardial rub that we sometimes find in terminal stages of renal disease. The cardiac condition is probably irrelevant in our present discussion.

The important physical findings are several discrete masses in the neck and a large abdominal tumor which from the rather vague description could be a spleen. If so, what enormous splenomegaly could lead to death within a period of 4 months? We have to think of leukemia but the laboratory reports no immature white cells in the smear. The white count is against leukemia as well as the absence of purpura. The increased platelets and the uric acid, however, are sometimes present in this condition.

The course of the disease is too rapid for a Hodgkin's and such a large spleen is seldom obtained. Then also, the constant fever of terminal Hodgkin's is not present. Tropical diseases can be ruled out. Metastatic malignancies of the spleen are very rare and not of this size. The few cases usually come from the breast or lung.

Lymphosarcoma involving the cervical, retroperitoneal and abdominal lymph-glands is a distinct possiblity. We have seen cases forming very large tumors which may be unilateral.

Then we have tumors of the kidney. Very diffuse metastases can occur rapidly either by way of the lymphatics or through the circulation. The tumors, when involving only one side, may not materially affect the renal function tests and there need not be hematuria.

The absent knee-jerks and the positive bilateral ankle clonus suggest metastasis to the lumbar spine.

Dr. Sweatt: There is a history of gastro-intestinal disturbance here. Maybe we should pay more attention to the diarrhea. Were the stools examined?

Dr. Beliveau: The stools were not examined.

Dr. Hirshler: There is no mention of a GI study. I assume that the condition of the gastro-intestinal tract was not considered too serious. The diarrhea can come from dietary causes.

Dr. Beliveau: What about the "boggy and red gums?"

Dr. Martel: I was thinking about that. Can't we have a leukemia of the aleukemic type here?

Dr. Beliveau: Not with 19,100 white cells and 82% polys.

Dr. Hirshler: This condition of the gums can also come from malnutrition.

Dr. Hirshler's Diagnosis

Tumor of the left kidney, probably hypernephroma, with metastasis to retroperitoneal, mediastinal and cervical lymph glands and to the spine.

Old mitral insufficiency.

Calcified uterine fibroid.

Anatomical Diagnosis

Squamous cell carcinoma of the left kidney with metastasis to entire abdominal, peribronchial, thoracic and cervical lymph glands, to lungs and liver.

Dr. R. A. Beliveau: Not mentioned in the history as you have it is a biopsy of one of the cervical glands diagnosed "squamous cell carcinoma, metastatic."

Squamous cell carcinoma, as you know, is a rarity in malignancy of the kidney and I picked this case mainly because of that fact. Dr. Hirshler is correct in his diagnosis except the type of tumor.

The kidney substance was completely replaced by tumor leaving only 3 or 4 pockets where the pelvis originally was. The "suggestion of a mass" in the epigastrium was a clump of retroperitoneal glands. She had cholecystitis and cholelithiasis. There was rheumatic heart disease. A calcified fibroid was found in the pelvis.

The great majority of renal malignancies occur in the kidney substance and a large proportion of these come under the classification of hypernephroma. Only 10% are in the kidney pelvis and most of these are villous carcinoma, papillary in nature, made up of cells resembling the papilloma but forming a large, spongy, easily bleeding mass which may invade the entire kidney. The main symptom in these conditions is hematuria and a retrograde pyelogram can usually demonstrate the tumor.

The squamous carcinoma is very unusual and results from prosoplasia of the lining epithelium of the kidney pelvis. The frequent association of calculi and carcinoma suggests irritation as a cause of the tumor but may also be the result of the new growth.

I have had printed for each of you a classification and incidence of kidney tumors. It may refreshen our memory if we go over the list together.

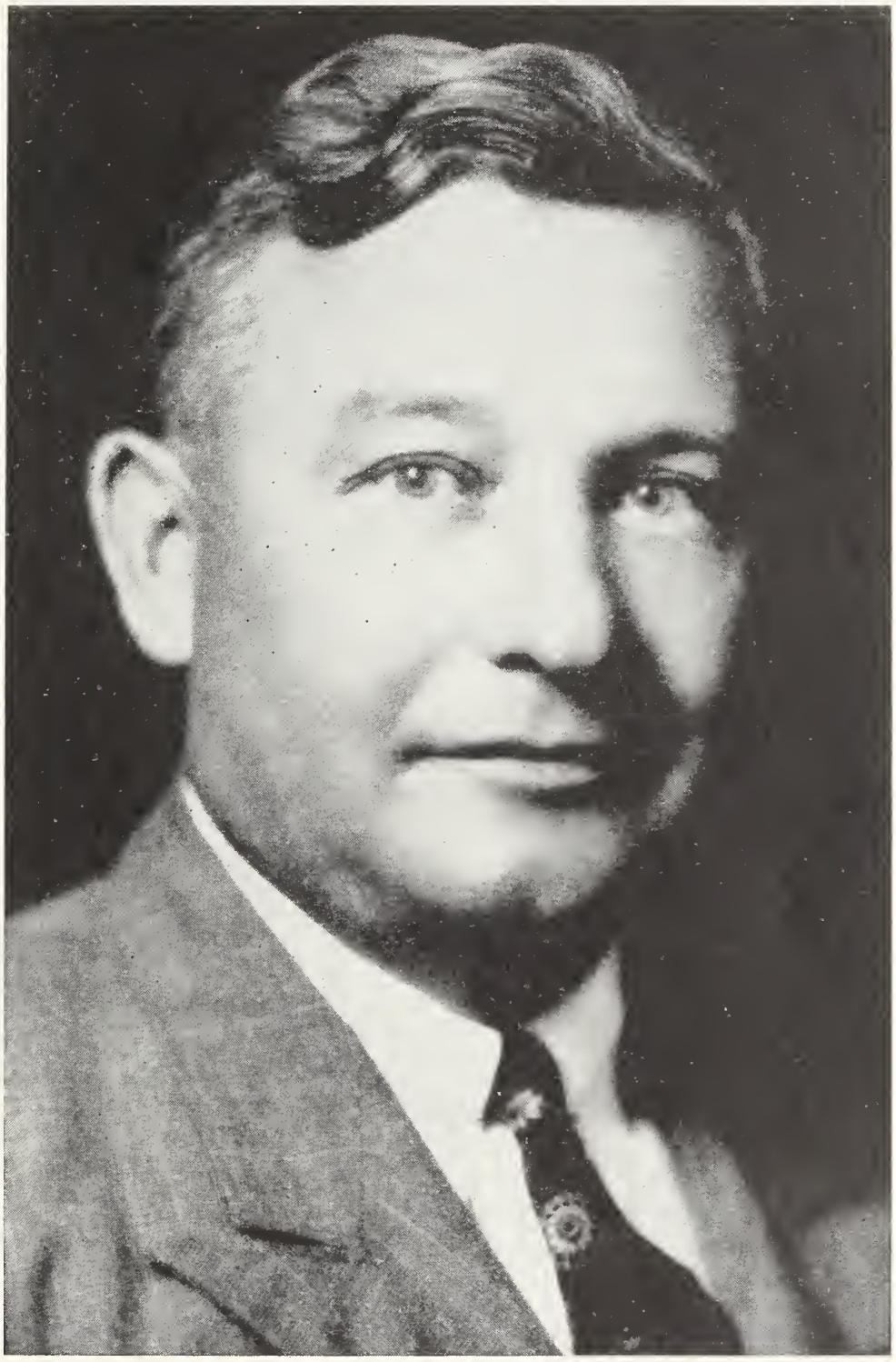
A. Classification of kidney tumors
 1. Renal tissue
 a. Benign
 1. Adenoma
 2. Fibroma
 3. Lipoma
 4. Angioma
 b. Malignant
 1. Carcinoma
 (a) Papillary adenocarcinoma
 (b) Alveolar adenocarcinoma
 2. Hypernephroma
 3. Sarcoma (including embryoma)
 2. Renal pelvis
 a. Benign
 1. Papilloma
 b. Malignant
 1. Villous carcinoma
 2. Squamous carcinoma

B. Type incidence of malignant kidney tumors in adults
 1. Kidney tissue
 a. Hypernephroma 71%
 b. Carcinoma 16%
 c. Sarcoma 3%
 2. Kidney pelvis
 a. Carcinoma 10%

C. Incidence of malignant tumors in children
 1. In 22,000 Boston Children's Hospital admissions, 0.2% incidence, classified as:
 a. Embryomatous 81%
 b. Sarcomatous 19%
 Probably all mixed tumors

D. Sarcoma rare 3%
 1. Type:
 a. Fibrosarcoma 40%
 b. Spindle cell 20%
 c. Miscellaneous 40%
 2. Age of patient:
 16 to 68 average 43
 3. Sex equal
 4. Prognosis:
 Poor 10% live over 2 years

Rehabilitation in tuberculosis should begin no later than the day the patient enters the sanatorium, because from the beginning he must know that there is still a future for him. This knowledge acquired early in illness makes a great difference in his morale and his manner of adjustment to a changed way of life. Herman E. Hilleboe, M. D., and Norvin C. Kiefer, M. D., *Pub. Health Rep.*, Mar. 1, 1946.



STEPHEN A. COBB, M. D.

President, Maine Medical Association

1947 - 1948

Stephen A. Cobb, M. D.

Stephen A. Cobb, M. D., of Sanford, incoming President of the Maine Medical Association is well known to all of its members.

He was born in Gardiner, Maine, December 9, 1887. He was graduated from Gardiner High School in 1905, Bates College in 1909, and received his medical degree from Harvard Medical School in 1914. He started his practice in Sanford in 1915.

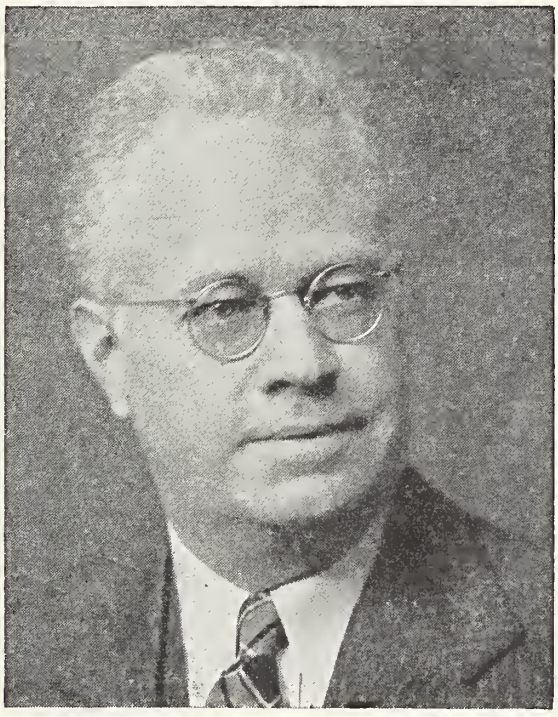
Doctor Cobb has been active in Association affairs for many years, having served on the Scientific Committee for three years, one year as Chairman, and as Councilor for the First District for three years, the last as Chairman.

He is a member of the New England Surgical Society, the American College of Surgeons, the Royal Society of Medicine, a Fellow of the American Medical Society, and a member of the Maine Medical Association, and the York County Medical Society. He is Vice President of the New England Council of State Medical Societies.

Doctor Cobb has seen service in World Wars I and II, starting as a 1st Lieutenant in World War I, he spent one year in France with the A. A. F. and came out a Captain. In September, 1942, he was again called to duty as Chief of Surgical Service with the 67th General Hospital, and was later appointed Executive Officer of the U. S. Army General Hospital in England. He was stationed in England three years, and held the rank of Colonel on his discharge from service.

Doctor Cobb received the Honorary Degree of Doctor of Science from the University of Maine, June 15th, 1947.

The Association is fortunate in having as its President a man of Dr. Cobb's calibre. We predict a very successful administration.



Forrest B. Ames, M. D., President-elect

Forrest B. Ames, M. D., of Bangor, was elected President-elect of the Maine Medical Association at a General Assembly held Monday afternoon, June 23rd, 1947, during the 93rd annual session at York Harbor.

Doctor Ames was born in Bangor, Maine, May 16, 1891. He was graduated from Bangor High School in 1909, the University of Maine in 1913, and from Harvard Medical School in 1919. He practiced medicine in Boston from 1920 to 1923, and since then has been located in Bangor. He specializes in Roentgenology and has been connected with the Eastern Maine General Hospital at Bangor for many years.

He is a member of the American Roentgen Ray Society, the New England Roentgen Ray Society, the Radiological Society of North America, Inc., and the American College of Radiology, a Fellow of the American Medical Association, and a member of the Maine Medical Association and the Penobscot County Medical Society, having served as Secretary-Treasurer of the latter for several years.

He has served on various Maine Medical Association committees, and as Councilor for the Sixth District for four years, the last two as Chairman.

Doctor Ames is well qualified to serve the Association as its President-elect, and it is hoped that he will receive the whole-hearted support and coöperation of the members, on whose behalf I hereby extend congratulations and best wishes.

Councilors and Council Chairman Elected at the 93rd Annual Session

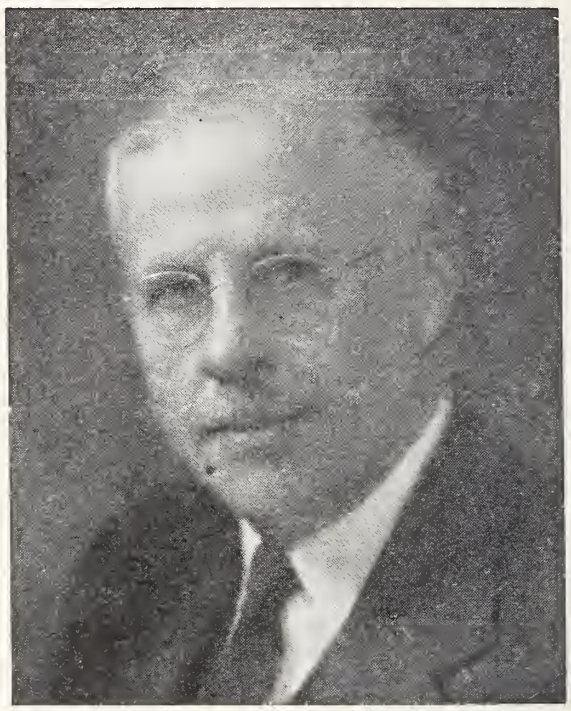
of the

MAINE MEDICAL ASSOCIATION

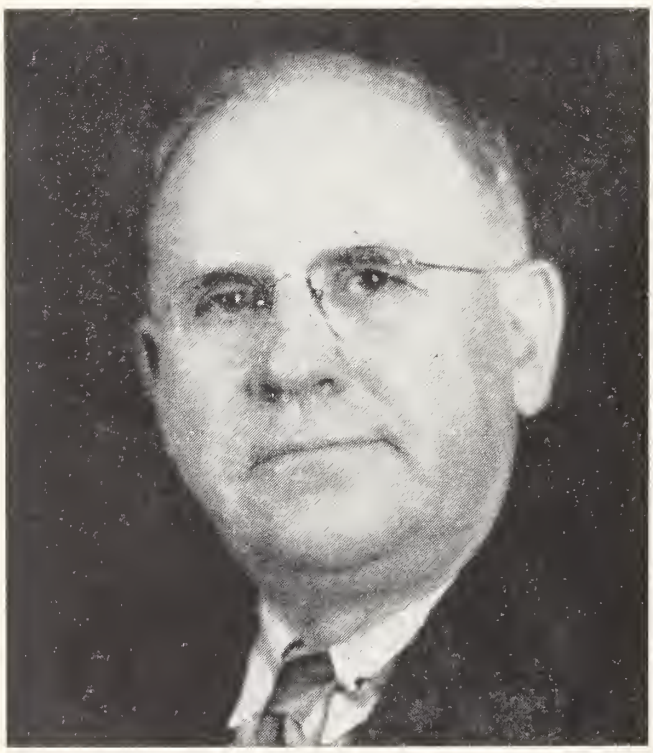
YORK HARBOR *JUNE 22, 23, 24, 1947*



Ralph A. Goodwin, M. D.
Auburn
Chairman, 1947 - 1948



C. Harold Jameson, M. D.
Rockland
Councilor, Third District, 1950



Foster C. Small, M. D.
Belfast
Councilor, Fourth District, 1950



Edward L. Herlihy, M. D.
Bangor
Councilor, Sixth District, 1949

The President's Page

There is an old quip that goes, "If you can't say good things about anyone, then say nothing." I am hoping that this year we will adhere to this and stop knocking the other systems of Medicine. Ever since 1929, when we allowed the Osteopath to slip in the Back Door, many of their members without preparation have more boldly and illegally practiced our system of Medicine. Every protest to the legislature, or knocks to the general public, instead of helping our cause, has boomeranged against us. Their cry is discrimination and persecution. We are in turn called the Medical Trust.

When I was in England, I asked a member of Parliament how it happened that they passed the Beveridge Plan, or so-called Socialized medicine. His reply was something as follows: "Well, you see Medicine is becoming so broad, and is divided into so many branches, that one man cannot possibly learn it all. Consequently we are now developing super-specialists, ordinary specialists, and sub-specialists. The super-specialist will gradually learn more and more about less and less, so that in the end he will know everything about nothing. On the other end of the scale, however, is the poor General Practitioner, who is learning less and less about more and more. You can see he winds up eventually knowing nothing about everything. Legislature had to step in to see if it couldn't level this thing off."

Now the same condition exists in this country. The Medical student spends at least six years out of High School, before he gets his degree, and two more years in a hospital as an interne before he is allowed to practice. Then if he wants to become a Specialist he has to spend four or five years as a Resident in Approved Hospitals before he can become a Diplomate in his Specialty. Do you wonder that the General Practitioner is going out of the picture. Do you wonder that it is almost impossible to get an M. D. to locate in a place where there is no Hospital. Consequently every time one of our older Doctors die it is an Osteopath that locates in his place. He surely is better than no Doctor at all. He is bound to make friends and adherents.

What can we do about it? The solution as I see it is to re-educate the people of the good old State of Maine. Ours is the best system of Medicine, and has "Stood the Test" of time. We have no quarrel with their system of Medicine. They have three Medical Schools that are approved by many States. Our kick is against certain of their members being allowed to practice, without knowledge of the Basic Sciences. For better health to the people of the State of Maine, and better Medicine to the sick, we must preach the gospel of having better prepared Doctors appearing before a Joint State Medical Board, or at least before a Basic Science Board in order to be registered.

I wish to thank you for the high honor that you have bestowed upon me.

Stephen A. Cobb, M. D.,
President, Maine Medical Association.

Editorial

The Ninety-third Annual Session of the Maine Medical Association

The Ninety-third annual session of the Maine Medical Association was held as scheduled at the Marshall House, York Harbor, Maine, June 22nd, 23rd, and 24th.

The attendance was very satisfactory. There were 236 members registered at the meeting, 161 guests, including Out-of-State speakers and delegates, and 45 representatives of the 34 Medical and Surgical Supply Companies who made up the largest Exhibit on record, and are to be commended for their support of the Association.

The Council met at 2.25 P. M., Sunday, June 22nd, and drew up the following Budget for 1947-1948 for the consideration of the House of Delegates:

President's Expenses,	$ 300.00
Salaries:	
Secretary-Treasurer-Editor,	3,000.00
Assistant Secretary,	2,500.00
Expenses—Secretary-Treasurer,	100.00
Office Expenses,	1,000.00
Committees:	
Medical Advisory,	1,000.00
Graduate Education,	100.00
Special Committees,	100.00
State Delegates and Council,	250.00
Delegate, American Medical Association,	250.00
Clinical Session, Maine Medical Association,	250.00
Council, New England Medical Societies,	100.00
Executive Secretary—Salaries and Expenses,	12,000.00
Total,	$20,950.00

The First Meeting of the House of Delegates was called to order at 3.00 P. M., Sunday. Included in the Order of Business was the appointment of a Reference Committee consisting of five members from the House of Delegates, and a Nominating Committee consisting of six members. The Council Report for 1946-1947 was presented by the Chairman, Dr. Forest B. Ames, of Bangor, who also presented the Budget for 1947-1948 as recommended by the Council, which was approved. Dr. Thomas A. Foster of Portland, Delegate to the American Medical Association, presented his report of the Centennial Session held in Atlantic City, June 9 to 14.

At the Second Meeting of the House of Delegates, held Monday, June 23rd, at 5.30 P. M., Dr. C. Harold Jameson, of Rockland, was elected Councilor for the Third District; Dr. Foster C. Small, of Belfast, was elected Councilor for the Fourth District; and Dr. Edward L. Herlihy, of Bangor, was elected Councilor for the Sixth District for two years, to complete Dr. Ames unexpired term. The Report of the Nominating Committee was presented by Dr. Martyn A. Vickers, of Bangor, Chairman, and is published elsewhere in this issue of the JOURNAL.

The Proceedings of the First and Second Meetings of the House of Delegates will be published in future issues of the JOURNAL.

Forrest B. Ames, M. D., of Bangor, was elected President-elect of the Association at the close of the General Assembly, Monday afternoon.

At the organization meeting of the Council held Tuesday, June 24th, Dr. Ralph A. Goodwin, of Auburn, was elected Chairman of the Council. Dr. Frederick R. Carter, of Portland, was re-elected Secretary-Treasurer of the Association, and Editor and Business Manager of THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION. Mrs. Esther M. Kennard, of Portland, was re-elected Assistant Secretary of the Association, and Assistant Business Manager of the JOURNAL.

Dr. Dexter E. Elsemore, of Dixfield, Chairman of the Scientific Committee, and members of his committee, are to be congratulated on the excellence of the scientific program which was enjoyed by all present.

Federal and State Legislation Relating to Compulsory Health Insurance

It is interesting to note the number of compulsory health insurance bills being introduced into the Federal Congress and the State Legislatures. The fact that so many are being introduced from time to time, and reintroduced in succeeding legislatures after defeat in previous ones, gives cogent reason to the medical profession to study the problem. It seems certain that there are some underlying conditions which are not wholly satisfactory. Legislators seldom present bills unless there is some demand for the change proposed.

In Congress at present there is the revised Wagner-Murray-Dingell Bill, this time introduced by Senator Murray for himself and Senators Wagner, Pepper, Chavez, Taylor and McGrath. Under this bill almost everyone who has any income would be eligible for benefits and the benefits include medical care in home or hospital or at the office, dental care, nursing and hospital care. The cost is unofficially estimated in the billions. This bill is designated as S. 1320 and is bitterly opposed by the A. M. A. It is not expected that either this bill or the Taft Bill (the latter having approval in principle of the A. M. A.) have any chance of enactment in the present Congress.

The California Legislature has been considering a compulsory health insurance plan sponsored by the Governor, Earl Warren. This bill has apparently failed of passage in the present session. Governor Warren insists that the bill will be passed during his term as governor so it will probably be reintroduced at another session.

Massachusetts has recently defeated a cash sickness insurance bill. This bill was sponsored chiefly by organized labor. It differs from the so-called compulsory health insurance bills in this respect,—the health insurance bills provide for payments to doctors, hospitals, dentists and nurses for those persons eligible to benefit on the basis of a schedule of fees agreed to by the doctors; the cash sickness insurance provides for payments direct to the sick person as a sort of disability indemnity.

Governor Driscoll of New Jersey is expected to call a special session of the Legislature to consider a cash sickness insurance program. This bill was defeated in the regular session of the Legislature. The Governor argues that if the states do not provide such a program, the Federal Government will.

The Wisconsin Legislature has before it a compulsory health insurance bill. It is very broad in its proposed benefits covering medical, dental and hospital care and nursing. It is to be financed by payroll deduction of 3% on all income up to $3,700, one-half to be paid by the wage earner, one-half by the employer.

There are two groups of people whose finances are such as to give vitality to these measures and present the underlying cause for their repeated presentation. First, there is that group of people called the medically indigent. They are people who make just enough money when they are employed to pay their regular, normal expenses. They never have enough to pay for even minor ailments. These people, by cooperation between Federal, State and local governments, would be cared for under the Taft Bill, S. 545.

The other group are the great mass of middle-income people who finance themselves and their ordinary expenses—including ordinary illnesses—but are not and cannot be prepared for catastrophic illness, with surgical fees and hospital expenses. The Blue Cross was founded for the purpose of budgeting the hospital expense through insurance, but that is only part of the bill. Voluntary prepaid medical care would allow provision through insurance for the surgeon's fees. Under such a plan as was contemplated by the proposed enabling act in the last Legislature, probably only surgery, obstetrics and treatment of fractures would

Continued on page 186

Nominating Committee Report

The report of the Nominating Committee as presented and accepted at the Second Meeting of the House of Delegates at the 93rd Annual Session of the Maine Medical Association, York Harbor, Maine, June 23, 1947.

MARTYN A. VICKERS, M. D., Bangor, *Chairman.*

Standing Committees
1947-1948

Scientific Committee

Francis A. Winchenbach, M. D., Bath (One Year), Chairman
Martyn A. Vickers, M. D., Bangor (Two Years)
Theodore E. Hardy, M. D., Waterville (Three Years)
Carl E. Richards, M. D., Alfred (Four Years)
The Secretary, ex-officio

Committee on Medical Education and Hospitals

David E. Dolloff, M. D., Biddeford (One Year), Chairman
Edward L. Herlihy, M. D., Bangor (Two Years)
Albert W. Fellows, M. D., Bangor (Three Years)

Medical Advisory Committee

Allan Woodcock, M. D., Bangor, Chairman
Carl M. Robinson, M. D., Portland
Frank A. Smith, M. D., Westbrook
Philip L. Gray, M. D., South Brooksville
C. Harold Jameson, M. D., Rockland
Oscar F. Larson, M. D., Machias
Forrest B. Ames, M. D., Bangor
Gerald H. Donahue, M. D., Presque Isle
The Secretary, ex-officio

Legislative Committee

The President, ex-officio
The President-elect, ex-officio
Frederick R. Carter, M. D., Portland, Chairman

Public Relations Committee

Frederick T. Hill, M. D., Waterville, Chairman
Roland L. McKay, M. D., Augusta
Dexter J. Clough, M. D., Bangor
Henry P. Johnson, M. D., Portland
Charles A. Steele, M. D., Lewiston

Cancer Committee

Arthur H. McQuillan, M. D., Waterville (One Year), Chairman
William Holt, M. D., Portland (Two Years)
Magnus F. Ridlon, M. D., Bangor (Three Years)
Forrest B. Ames, M. D., Bangor (Four Years)
Joseph E. Porter, M. D., Portland (Five Years)
Irving I. Goodof, M. D., Lewiston (Six Years)

Committee on Social Hygiene

Oscar R. Johnson, M. D., Portland (Three Years), Chairman
Storer W. Boone, M. D., Presque Isle (One Year)
Carl E. Blaisdell, M. D., Bangor (Two Years)

Publicity Committee

Frederick R. Carter, M. D., Portland, Chairman
President, Stephen A. Cobb, M. D., Sanford
President-elect, Forrest B. Ames, M. D., Bangor

Special Committees
1947-1948

As appointed by the President, Stephen A. Cobb, M. D., Sanford, in accordance with the By-Laws, Chapter V, Section I.

Committee on Graduate Education

Joseph E. Porter, M. D., Portland, Chairman
William V. Cox, M. D., Auburn
Eugene H. Drake, M. D., Portland
Magnus F. Ridlon, M. D., Bangor
George E. Young, M. D., Skowhegan
Wilfred J. Comeau, M. D., Bangor
M. Tieche Shelton, M. D., Augusta

Tuberculosis Committee

Francis J. Welch, M. D., Portland, Chairman
Walter R. Gumprecht, M. D., Bangor
Loren F. Carter, M. D., Presque Isle
Charles D. Cromwell, M. D., Fairfield
Lester A. Adams, M. D., Hebron
George E. Young, M. D., Skowhegan
Rufus E. Stetson, M. D., Damariscotta
Herbert S. Everett, M. D., St. Stephen, N. B.
Edward A. Greco, M. D., Portland

Committee on Maternal and Child Welfare

Thomas A. Foster, M. D., Portland, Chairman
Clair S. Bauman, M. D., Waterville
Leroy C. Gross, M. D., Auburn
Alice A. S. Whittier, M. D., Portland
Virginia C. Hamilton, M. D., Bath
Theodore M. Stevens, M. D., Portland

Committee on Industrial Health

Albert P. Royal, M. D., Rumford, Chairman
Isaac M. Webber, M. D., Portland
Edwin M. Fuller, M. D., Bath
Allan Woodcock, M. D., Bangor
Roscoe L. Mitchell, M. D., Augusta
Edwin W. Harlow, M. D., Waterville

Committee on Conservation of Vision

Howard F. Hill, M. D., Waterville, Chairman
S. Judd Beach, M. D., Portland
Jay K. Osler, M. D., Bangor
Warren E. Kershner, M. D., Bath
William R. McAdams, M. D., Portland

Amy W. Pinkham Fund Committee

Thomas A. Foster, M. D., Portland, Chairman
Virginia C. Hamilton, M. D., Bath
Albert M. Carde, M. D., Milo
Clair S. Bauman, M. D., Waterville
P. L. B. Ebbett, M. D., Houlton
John F. Hanson, M. D., Machias
Norman H. Nickerson, M. D., Greenville

Committee to Formulate Plans for Re-opening of Medical School of Maine

Edward L. Herlihy, M. D., Bangor, Chairman
Clyde I. Swett, M. D., Island Falls
Harvey C. Bundy, M. D., Milo
Frederick T. Hill, M. D., Waterville
Stephen A. Cobb, M. D., Sanford
Adam P. Leighton, M. D., Portland
Eugene H. Drake, M. D., Portland
Eugene E. O'Donnell, M. D., Portland
Wallace E. Webber, M. D., Lewiston
Leverett D. Bristol, M. D., Augusta

Veterans' Affairs Committee

Harold E. Pressey, M. D., Bangor, Chairman
Elton R. Blaisdell, M. D., Portland
Currier C. Weymouth, M. D., Farmington
Francis A. Winchenbach, M. D., Bath
Edward H. Risley, M. D., Waterville
Philip O. Gregory, M. D., Boothbay Harbor

Committee to Study Prepaid Medical Care Plans

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Edward L. Herlihy, M. D., Bangor
Clyde I. Swett, M. D., Island Falls
George O. Cummings, M. D., Portland
Frank A. Smith, M. D., Westbrook
M. Tieche Shelton, M. D., Augusta

COUNTY SOCIETIES

Androscoggin
President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, Edward A. Greco, M. D., Portland
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Secretary, Kenneth A. LaTourette, M. D., Farmington

Hancock
President, Raymond E. Weymouth, M. D., Bar Harbor
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Frank B. Bull, M. D., Gardiner
Secretary, Arch H. Morrell, M. D., Augusta

Knox
President, Wesley N. Wasgatt, M. D., Rockland
Secretary, Freeman F. Brown, Jr., M. D., Rockland

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President, Stanley R. Lenfest, M. D., Waldoboro
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Secretary, John E. Smith, M. D., Bangor

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President, John B. Valentine, M. D., Dover-Foxcroft
Secretary, Norman H. Nickerson, M. D., Greenville

Somerset
President, Richard P. Laney, M. D., Skowhegan
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Waldo
President, Seth H. Read, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

Kennebec

A regular meeting of the Kennebec County Medical Association was held at the Veterans' Facility, Togus, Maine, on May 15, 1947. An excellent dinner was served at 6.30 P. M., which was enjoyed by 52 members.

After moving from the nurses home to the hospital, where a most excellent clinical program was presented, a brief business meeting was held. The record of the previous meeting was read and approved.

The application of Dr. Darlington was received and referred to the Council.

Dr. Meyer Manuel of Togus was elected to membership by transfer from the Nassau County Medical Association of New York.

There followed very instructive case discussions by Dr. John Nelson and Staff on "Malignancy in Young Men," Dr. Josef Giesen on "Orthopedic Problems," and Dr. Kirkham and Staff on "Addison's Disease"; discussion by Dr. Merton G. Brown of Boston.

The incidence of malignancies in young men is certainly interesting. All the cases presented were thoroughly worked up and and one is impressed with the high quality of the care they are receiving.

A. H. Morrell, M. D.,
Secretary.

News and Notices

Receives Honorary Degree

Stephen A. Cobb, M. D., of Sanford, President of the Maine Medical Association, received the Honorary Degree of Doctor of Science from the University of Maine, Orono, on June 15, 1947.

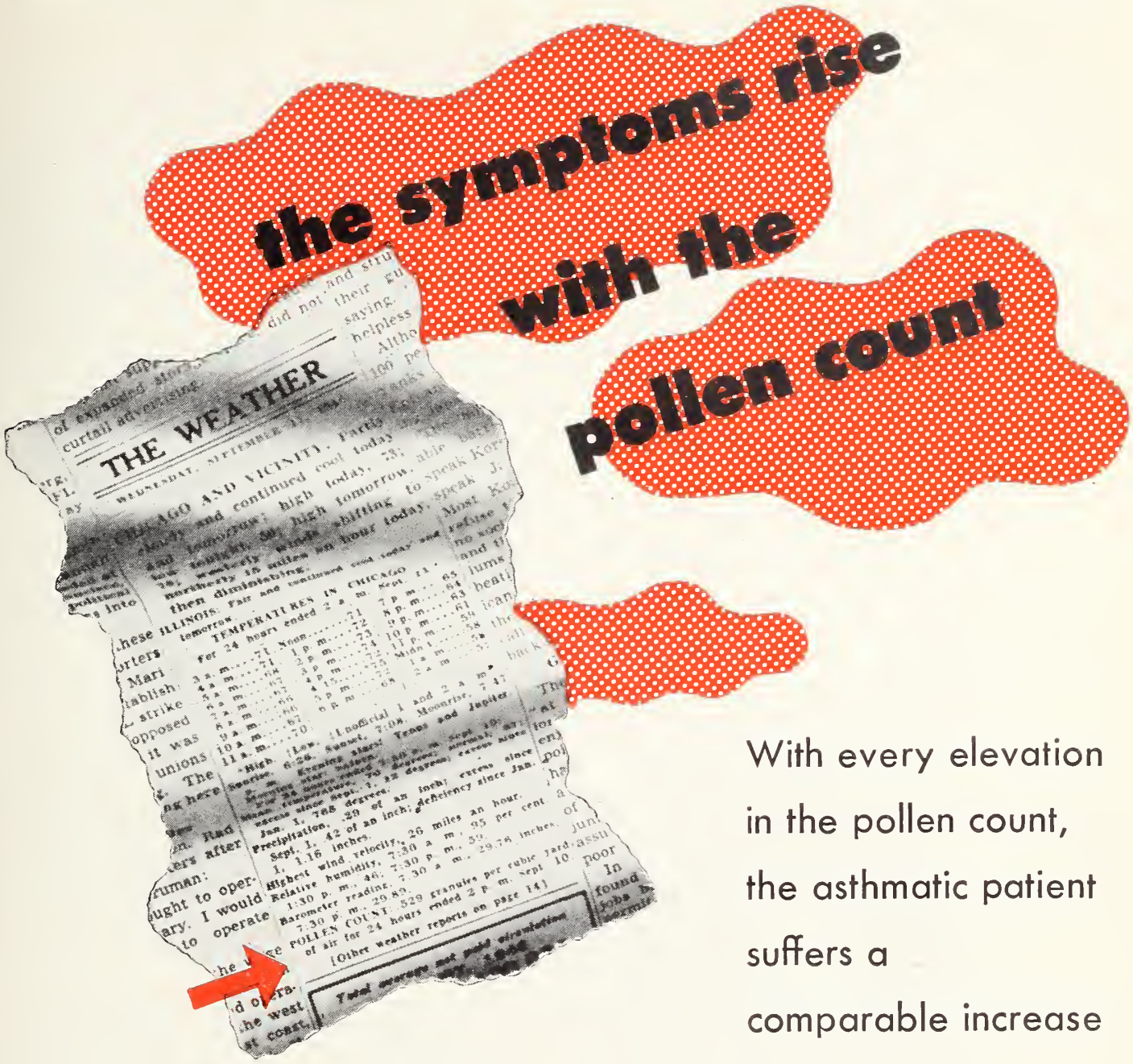
Appointed Commissioner of Health and Welfare

David H. Stevens, of Belfast, was appointed Commissioner of the Maine Health and Welfare Department by Gov. Horace A. Hildreth, on June 19, 1947. Mr. Stevens, state tax assessor for the past five years, will succeed Dr. Leverett D. Bristol, who resigned recently.

Maine Psychiatric Society Founded

The Maine Psychiatric Society was founded at the Augusta State Hospital, Augusta, Maine, on June 19, 1947. The object of the society is group consideration of all matters relating to psychiatry in the State. Officers elected are:

Continued on page 182



With every elevation in the pollen count, the asthmatic patient suffers a comparable increase in the severity of symptoms. In the dyspnea of allergic asthma, Aminophyllin has been found to provide efficient relief.

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SEARLE

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OF MEDICINE

President, Carl J. Hedin, M. D. (Superintendent, Bangor State Hospital), Bangor.

Vice-President, Frederick R. Carter, M. D., Portland.

Secretary-Treasurer, Francis H. Sleeper, M. D. (Superintendent, Augusta State Hospital), Augusta.

Councilors, George L. Wadsworth, M. D., Veterans' Facility, Togus; Forrest C. Tyson, M. D., Winthrop.

Jackman Has to Have a Doctor

Jackman, Maine, is separated by 50 miles of forest in every direction from the nearest other towns having psysicians. Jackman has always had a physician. By the end of July, however, our doctor will have left us in order to specialize.

Jackman has to have a doctor.

Our town and the surrounding towns of Moose River, Long Pond, Holeb, and Dennistown have a population totalling about 2,000. In addition to this there is the Convent of the Sacred Heart with a boarding school population of about 250 children. The practice also includes an additional 500 or more men in the surrounding lumbering camps as well as the numerous tourists and sportsmen who visit us yearly. Jackman is located on the Federal Highway running from Portland to Quebec, and on the main line of the Canadian Pacific Railroad. There is airplane service into town. Jackman is just below the Canadian border and is a government Port of Entry.

Our present doctor has tried to locate another physician for us but without success. His home, which contains an office wing is for sale and would be available for another physician. He has stated that he would be glad to introduce a new physician to the public of this region. Any doctor who might be interested in settling here is urged to write at once to the undersigned, or to come right up to look the situation over.

Mrs. Joan Ferland,
Jackman Station, Maine.

International College of Surgeons to Hold Annual Assembly at Chicago

The International College of Surgeons, United States Chapter, will hold its Twelfth Annual Assembly and Convocation in Chicago, September 28 to October 4, 1947.

The program will include operative and non-operative clinics, demonstrations, symposia, forums, medical motion pictures, exhibits and the formal dedication of the new library and permanent home of the United States Chapter. All meetings, with the exception of the operative clinics, will be held in the Palmer House and the Stevens Hotel.

The Cook County Hospital of Chicago has reserved Friday, October 3, for operative clinics, round table discussions and demonstrations for the attending Fellows of the College. Twenty other hospitals of Chicago will be hosts at surgical clinics and demonstrations on October 4.

General Chairman of the meeting is Raymond W. Nealy, M. D., Chicago; and Co-chairman are Karl Meyer, M. D., and Max Thorek, M. D., of Chicago.

Louis J. Gariepy, M. D., of Detroit, Secretary of the U. S. Chapter, announced that the annual meeting of the House of Delegates and election of officers would be held on September 28 and 29 immediately proceeding the Assembly and Convocation. Presiding will be President Herbert Acuff, M. D., of Knoxville, Tennessee.

Copy of the program and detailed information may be obtained by writing Max Thorek, M. D., Co-chairman, 1516 Lake Shore Drive, Chicago, Illinois.

The American Congress of Physical Medicine

Will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6 inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be help September 2, 3, 4 and 5. These courses will be open to physicians and the therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

For Rent

Two-room office at 756 Congress Street, Portland, Maine. Receptionist Service. For further information call Telephone 2-1631.

Treasurer's Report

To the Officers and Members of the Maine Medical Association:

The books of the Association and JOURNAL were closed and audited as of May 31, 1947, by Jordan and Jordan, Accountants and Auditors, Portland, Maine, who "found the same complete and correct in all details of record," and submitted the following statements "properly drawn up to show the true financial position of the Association, May 31, 1947, and the income and expense for the year under review." An itemized report of expenses of the Executive Secretary's office from November 1, 1946, to May 31, 1947, as prepared by your Treasurer, follows the Auditor's Statements.

FREDERICK R. CARTER, M. D.,
Treasurer.

BALANCE SHEET, MAY 31, 1947

ASSETS

Cash in Banks		$26,575.23
Accounts Receivable:—		
Dues	$1,225.00	
Advertising	740.63	
		1,965.63
Securities		9,765.00
Furnishings and Equipment		1,092.59
Deferred Expenses—Annual Meeting		16.58
Trust Fund Investments		2,554.65
Total Assets		$41,969.68

LIABILITIES

Withholding Taxes	$211.50	
Deferred Income—Convention Exhibit Space	571.00	
Total Liabilities		782.50
Assets in Excess of Liabilities		$41,187.18

CAPITAL AND TRUST FUNDS

Capital Account	$38,632.53	
Trust Funds	2,554.65	
Total Capital and Trust Funds		$41,187.18

CAPITAL ACCOUNT

Balance, June 1, 1946	$26,150.55
Deduct:—	
Accounts Receivable Charged Off	18.00
	$26,132.55
Add:—	
Revenue in Excess of Expense —One Year	12,499.98
Balance, May 31, 1947	$38,632.53

TRUST FUNDS AND INVESTMENTS
MAY 31, 1947

Prince A. Morrow Trust:—		
12 shares American Agricultural Chemical Co. (Cost)	$ 348.00	
Canal National Bank — Savings No. 3905	1,039.03	
		$1,387.03
Thayer Library Trust:—		
Canal National Bank — Savings No. 3903		1,167.62
Total Trust Fund Investments		$2,554.65
Trust Funds:—		
Prince A. Morrow Fund:—		
Principal	$554.94	
Income	832.09	
		$1,387.03
Thayer Library Fund:—		
Principal	$1,154.20	
Income	13.42	
		1,167.62
Total Trust Funds		$2,554.65

STATEMENT OF REVENUE AND EXPENSE
ONE YEAR ENDED MAY 31, 1947

REVENUE

Dues		$25,807.00
Income from Investments		481.03
C. M. A. B. Advertising		7,132.50
Local Advertising		924.35
Subscriptions and Sales of JOURNALS		18.40
Exhibit Space Rentals — Convention		1,049.00
Total Revenue		$35,412.28

EXPENSE

Secretary and Treasurer's Office:—	
Salary — Secretary, Treasurer and Editor	$2,200.04
Assistant Secretary	2,000.00
Office Assistance	17.00
Travel — Secretary and Councilors	215.54
Office Expenses:—	
Supplies and Stationery	408.97
Postage and Mailing Expense	258.43
Rent	300.00
Light	12.00
Auditing	68.95
Telephone	175.97
Surety Bond	5.00
Advertising	25.00
Books, Magazines, Periodicals	24.40
Miscellaneous	46.55
A. M. A. Meeting	542.81
Medical Advisory and Special Committees	594.62
Annual Meeting	1,025.24

Clinical Sessions	219.04	
Health Council of Maine	300.00	
Delegates—New England Medical Societies	82.00	
Council—New England Medical Societies	100.00	
	$8,621.56	
Printing	$6,911.38	
Plates	216.35	
	$7,127.73	
Executive Secretary's Office:—		
Seven Months	$7,163.01	
Total Expenses		$22,912.30
Revenue in Excess of Expense — One Year		$12,499.98

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

ONE YEAR ENDED MAY 31, 1947

Cash in Banks—June 1, 1946		$14,925.59

RECEIPTS

Received from Dues	$24,882.00	
Income from Investments	481.03	
Exhibit Space Rentals	1,200.00	
Subscriptions and Sales of JOURNALS	18.40	
Advertising	7,841.19	
Withholding Taxes	965.91	
		35,388.53
		$50,314.12

DISBURSEMENTS

Secretary and Treasurer's Office:—		
Salaries	$ 4,217.04	
Traveling and Other Expenses	215.54	
Office Expenses	1,325.27	
A. M. A. Meeting	542.81	
Annual Meeting	1,039.82	
Delegates to New England Medical Societies	82.00	
Council of the New England Medical Societies	100.00	
Clinical Sessions	219.04	
Health Council of Maine	300.00	
Medical Advisory and Special Committees	594.62	
Withholding Taxes	812.01	
Printing and Plates	7,127.73	
	$16,575.88	
Executive Secretary's Office:—		
Seven Months	7,163.01	
		23,738.89
Cash in Banks — May 31, 1947		$26,575.23
Canal National Bank — Checking Accounts	$18,448.63	
Canal National Bank — Savings Accounts	1,737.08	
Maine Savings Bank	2,975.47	
Portland Savings Bank	2,933.55	
First National Granite Bank	480.50	
		$26,575.23

SECURITIES

MAY 31, 1947

BONDS

$2,000 Commonwealth of Australia, Ext. Loan 30-yr. 5's, 1957	$1,960.00
$3,000 Portland Terminal Company, 1st Mtge. 5's, 1961	3,045.00
$700 Prudence Bond Corp., 1st Mtge. Coll. Series 6, 5½'s, 1936 (Defaulted)	700.00
$4,000 U. S. Savings Bonds "G" Due July 1, 1956	4,000.00

STOCKS

10 Shares Mortbon Corp. of N. Y.	60.00
Total Securities	$9,765.00

EXPENSES — EXECUTIVE SECRETARY

NOVEMBER 1, 1946 - MAY 31, 1947

(As prepared by the Treasurer, Dr. Carter)

Salaries:		
Executive Secretary	$3,791.66	
Secretary	928.00	
Office Expenses:		
Equipment	418.25	
Supplies and Stationery	94.37	
Maine Register	10.00	
Petty Cash	15.00	
Subscription, Public Health Economics	3.00	
Dues, Medical Society Executives Conference	5.00	
Portland Directory	20.00	
Rent and Lights	303.23	
Telephone	45.03	
Postage	30.00	
Legislative Session:		
Room, Transportation, Meals, Entertainment, and etc.	1,000.01	
Miscellaneous Expense:		
Document Service	14.00	
Transcription Medical School Bill	35.00	
Mimeograph Supplies and Reports	20.55	
Conference with Dr. Herlihy Re: Medical School Bill	23.14	
Prepaid Medical Care Plan Meeting, Hartford, Conn.	10.86	
Maine Medical Association, Clinical Session, December, 1946	20.53	
Conference, Secretaries and Editors, A. M. A., December, 1946	186.11	
Rotary Club, Rumford, December, 1946	10.50	
New England Medical Council, January, 1947	14.84	
Rural Health Meeting, A. M. A., February, 1947	152.33	
County Medical Society Meetings: Room, Transportation, Meals	135.21	
Total		$7,286.62
Refund from American Medical Association (account Conference Secretaries and Editors)		123.61
Total Expenses, Seven Months		$7,163.01

Recent Advances in Pediatrics—Continued from page 164

and reaction to the drug should be obtained. The urine should be checked and the hemoglobin and white count should be determined and repeated at intervals if possible. Adequate fluid intake should be provided and intake and urine output measured. The temperature should be charted and the patient should be examined daily for rashes, pallor or jaundice.

Penicillin and streptomycin are the only antibiotics available for general use at the present time.

Penicillin is especially indicated in all staphylococcus infection with or without bacteriemia. Penicillin has about the same use as sulfadiazine but it is especially indicated in staphylococcus infection. It is, however, contraindicated in typhoid, dysentery, tuberculosis, acute rheumatic fever, malaria and poliomyelitis.

Streptomycin is especially useful in influenza meningitis in combination with sulfadiazine. Our experience in tubercular meningitis has been disappointing. It has seemed only to prolong the disease.

On the Prevention of Coronary Disease—Continued from page 166

7) Cantarow, Abraham. Jefferson Medical College. Personal communication.

Additional Bibliography

Ferguson, John. Cholesterol and the Heart: Its effect on the activity of the Heart of the Frog and the Turtle. *Canadian Medical Journal,* Vol. 47, pp. 60-62.

Hueper, W. C. Experimental studies in cardiovascular pathology. *Archives of Pathology,* 41:139, Feb., 1946.

Member, Samuel, and Bruger, Maurice. Experimental atherosclerosis. *Archives of Pathology,* Nov.-Dec., 1945, Vol. 40, pp. 373-375.

Bassler, Anthony. Coronary disease and the intestine. *Medical Record,* April 1, 1942, Vol. 155.

Roark, J. P. A method of treatment addressed to the cause of coronary heart disease. *Illinois Medical Journal,* Vol. 77, No. 3, March, 1940.

Reitman, Norman. Coronary Thrombosis in a young diabetic. *American Journal of Medical Sciences,* Vol. 203, No. 6, June, 1942.

Shaffer, Carl F. The nutritional role of cholesterol in human coronary arteriosclerosis. *Annals of Internal Medicine,* Vol. 20, June, 1944.

Simple Tests for Sugar—Continued from page 167

surface. Then two or three drops of urine are dropped on the powder so as to saturate it. It is essential to moisten all the powder. If acetone is present the powder turns within a minute to some shade of purple, with the intensity of color depending on the amount of acetone present. If no acetone is present the powder will take on a greyish yellow color.

Conclusion

This paper presents simple tests for detecting sugar and acetone in urine. Because of the simplicity and rapidity with which these tests may be done, they appear to be valuable laboratory procedures for office and hospital use. They also appear worthwhile for diabetic patients to use in testing their own urine frequently.

References

(1) Blotner, H.: Studies in Glycosuria and Diabetes Mellitus in Selectees. *J. A. M. A.,* 131:1109. Aug. 3, 1946.

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Federal and State Legislation—Continued from page 177

have been afforded coverage under the policy. A schedule of fees for each type of operation or treatment would have been set up and agreed to by the physicians participating.

The way is still open to study insurance policies written by existing companies or even to suggest to such companies as may be interested, a form of policy to meet this situation. Insurance companies usually write an indemnity policy. Under this policy a certain amount is paid according to a schedule of fees set in the policy itself. The physician makes no agreement to accept that amount as his fee but is free to charge either more or less as he feels proper for the case. Under both systems—the physician-sponsored insurance or the insurance company policy—the patient has free choice of doctors.

For the medically indigent, nothing except charity and free treatment by the doctors or government provision for payment, such as the Taft Bill, can be done; they are financially unable to budget for illness. For the second or middle-income class group, physician-underwritten or physician-sponsored insurance seems a remedy for existing hardship. The well-to-do can and do have no cause for complaint or unrest with the best medical service in the world which they can afford to pay for.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine Eye and Ear Infirmary Maine General Mercy	1st Wednesday 2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

Book Reviews

"A History of the American Medical Association, 1847-1947"

A History of the American Medical Association, 1847-1947, by Morris Fishbein, M. D., with biographies of the Presidents of the Association by Walter L. Bierring, M. D., and histories of Publications, Councils, Bureaus, and other Official Bodies. 1226 pages. Published by W. B. Saunders Company, Philadelphia & London.

This book is published in recognition of the 100th Anniversary of the American Medical Association which was held in Atlantic City, June 9-13, 1947. It reviews the rise of the Association as a great organization, and has reference particularly to campaigns to raise the standard of medical education, to eliminate quackery, to improve industrial health, to eliminate nostrums and frauds in the medical field, and to provide a high quality of medical care. It is written for the public as well as for the medical profession.

"Diabetic Care in Pictures"

Simplified Statements with Illustrations Prepared for the Use of the Patient

By Helen Rosenthal, B. S., Associate Dietitian in the Food Clinic, The Boston Dispensary; Assistant in Medicine, Tufts College Medical School.

Frances Stern, M. A. (Honorary), Chief of the Food Clinic, The Boston Dispensary; Instructor of Medicine, Tufts College Medical and Dental Schools; Special Instructor in Dietetics in Social Service, Simmons College, The School of Social Work; Associate in Nutrition, Simmons College School of Home Economics.

Joseph Rosenthal, M. D., Chief of Diabetic Clinic, Assistant Medical Director, Medical Supervisor of the Domiciliary Medical Service, The Boston Dispensary; Assistant Professor of Medicine, Tufts College Medical School; Associate Physician, Joseph H. Pratt Diagnostic Hospital.

137 Original Illustrations (including 4 in color). Prepared under the direction of the authors.

Published by J. B. Lippincott Company, Philadelphia, London, Montreal, 1946. Price, $2.00.

This inexpensive book has been prepared for the instruction of the patient with diabetes. It teaches the patient so that he can carry on and live a normal life. Diabetics must do many things for themselves and the pictures in this book serve as a helpful guide in carrying out the procedures necessary for home treatment.

Medical Advertisement



From where I sit
by Joe Marsh

How to Go to Sleep

We were sitting around Bill Webster's parlor Friday evening and the talk turned to the best way of overcoming sleeplessness . . . like breathing real slow, imagining that you weigh a ton, or simply throwing away the pillow.

The consensus favored counting sheep. But right away was the question: what *kind* of sheep? There were some votes for Merinos, Shropshires, Oxfords and Dorsets. Ed Carey said he had best luck counting crossbreeds.

Finally, Bert Childers spoke up with his formula: A light snack and a mellow glass of beer at bedtime. Sort of puts you in the right mood for quiet thoughts and peace of mind. Lets you relax . . . and "ho hum," off to pleasant dreams!

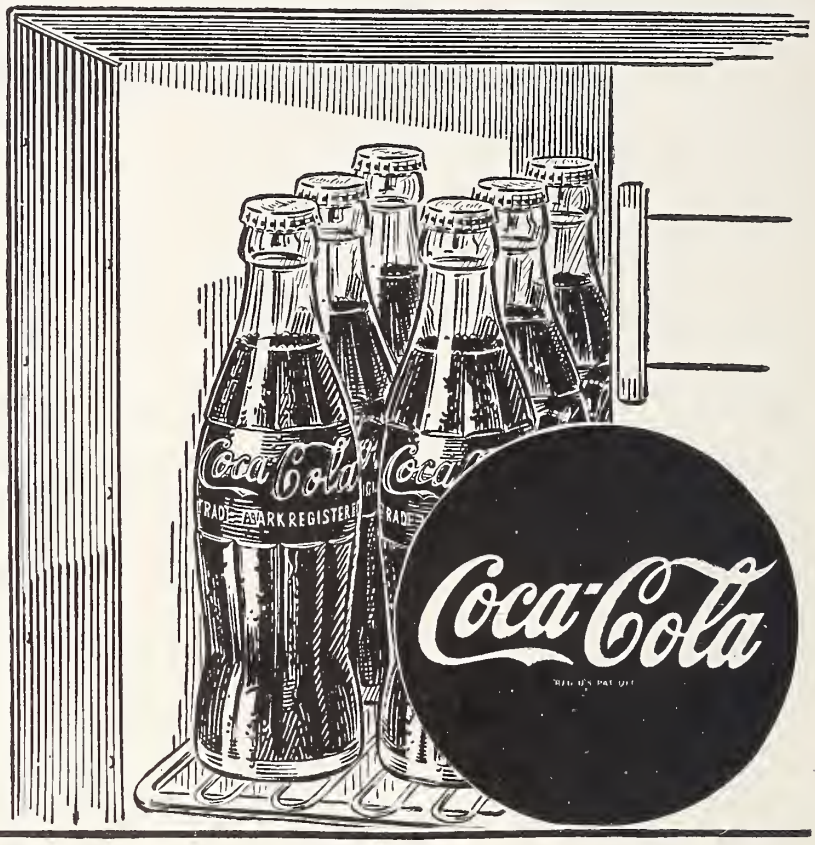
From where I sit, there's nothing like a temperate glass of beer to smooth away the creases of the day, relax a body, and pave the way for a good night's sleep. Try it some night, and see if I'm not right.

Joe Marsh

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FREE FORMULARY

DR._____

ADDRESS_____

CITY_____

STATE_____

The Journal of the Maine Medical Association

Volume Thirty-eight Portland, Maine, August, 1947 No. 8

*Presidential Address**

John O. Piper, M. D., Waterville, Maine

As retiring President of this Maine Medical Association, I wish to thank you for giving me the very great honor and privilege of serving you in that capacity during the last year.

I want to thank the various committees, who have worked so untiringly and efficiently during the year. I think the type of program which has been furnished, shows the kind of work the committees have been doing.

We have not attempted to go into much new work this year, but have made an effort to carry out some of the measures voted by the House of Delegates last year.

This being a legislative year in our State Government, we have attempted to put through these measures, which if they were passed, we thought might help the Medical situation in our State.

As you know, the plea for a Medical School in Maine was voted down in the Senate. However, at the Hearing before the Committee, it was really gratifying to hear the favorable comment expressed.

Nevertheless, the answer was that there is just NOT sufficient money, and if this measure could be passed, no way could be figured out to get that money.

I want to say, however, that it was not any lack of honest endeavor on the part of the committee in charge of the Bill, that we did not get a Maine Medical School.

Our executive secretary certainly worked hard to get the Bill passed, and deserves a great deal of credit for all the work he put into it.

The Bill, for obtaining from the Legislature, an enabling act to form a non-payment Insurance Plan, also failed to pass, and this was a great surprise to me. The amount of opposition, which this Bill received from our own Association was certainly astonishing, and if I had realized such was the case, I for one, would have been very much opposed to the measure coming before the Legislative Committee at all.

That issue was fully discussed before the House of Delegates, and there was not any dissention. We'll mention this subject again later on.

Naturally, I have read and heard a great deal about the many changes that are confronting

* Presented at the 93rd Annual Session of the Maine Medical Association at York Harbor, Maine, June, 1947.

us in our dealings with the public in the science and art of the practice of medicine.

We know there have been very great changes in the economic structure, which our country has developed.

At first, we were a farming community, with the desires and the viewpoints of such society.

Then these various communities, situated all over our Country, were fairly independent, and able to care for their own needs, and look after their poor and indigent very well.

The situation has entirely changed, until now, we find ourselves a highly industrialized Nation, with our population mostly urban, instead of rural as it was before.

The average man today, is largely dependent upon his daily wage, which fluctuates greatly with the law of supply and demand, until now, practically the whole Nation finds itself in this predicament.

The advent of highly specialized machinery has had a tremendous effect on the employment of men, in fact, this is being called the machine age. We know that no Nation on earth has begun to make the use of machinery in their daily lives that the United States has.

We all know that the winning of World War II was in a great measure due to the intelligent use of the various machines, which enabled us to do the magnificent job which no one thought could be done, in the mass production of war machinery.

With these changes in the economy of our Country, have come about marked changes in the workings of the Medical Profession. Maybe this state of Medical affairs may have come first, and been more or less a cause of the economical changes. I will try to elucidate:—

First, there have been such great advances in the prenatal and subsequent care of the newborn babe, that the expectancy of life, in the new form, has changed, even in my time, from about the age of 40 to 68.

Smallpox has been pretty well stamped out. Typhoid fever has ceased to be a great menace to the health of a community. Diphtheria also is nearly conquered, and lately Pneumonia's death rate has gone from 20 to 50% mortality, down to 3 to 5%.

This does not even scratch the surface of what has been done and is constantly being done in the conservation of human life and the banishment of disease.

We have seen all sorts of specialists develop all over our Country and these have become specialists because they understand some highly specialized piece of machinery.

Viz: Urology exists largely because the urologist is highly proficient in the use of a Cystoscope.

A Cardiologist, because he understands and uses the Electrocardiagraph with intelligence, the bronchoscopist, the bronchoscope, and so on. Thus we see that this can be well called a machine age in the practice of medicine. With the aid of these mechanical devices, specialists were able to create the great mass production which they did, in 1942 to 1947.

There has necessarily been a great change in the type of population in our Country. The average age has changed tremendously, bringing about changes in social policy, relative to the care and security of the aged. This has complicated the vocational adjustments of all age groups, especially of youth.

Modern medicine has proved its scientific efficiency to such an extent, that when any segment of the population is deprived of its benefits, it recognizes a serious disadvantage.

The problems of Medical practice that are agitating the public today, are therefore primarily concerned with the provision of light quality curative and preventative medical care to all the people, whether they belong to low or high income groups, rural or urban residents, negroes or whites.

It would seem that the future prestige of medicine, and its further contribution to scientific and social progress are closely related to the solution of these problems. That they are vital has been shown the last year or two by the fact that there has already been a serious threat to have the whole medical profession taken over and operated by the Government.

An attempt to do this was made in the Philippines, but was defeated so that at present the practice of Medicine is still a free institution.

We wonder if a great part of this sudden dilemma has not been thrust upon us because we, in our intense pursuit of the scientific side of medicine, have not forgotten that after all, we have an art as well as science.

In the past, the medical doctor took no one into his confidence, and let John Public think there was something very mysterious about it all. We believe that this has persisted, or at least we have neglected to inform people that all our effort to obtain more knowledge is far more for their benefit than ours.

The Michigan State Medical Society sums up the situation facing the Medical Profession with these words, "Organized medicine has the public welfare at heart, but it remains to be demonstrated to the people."

The Michigan State Society, after a careful study of these conditions in their State, came to the conclusion that they must have a certain public relations policy, which sounded *good* to me. They finally sent a message to every Physician in the State, outlining some of its public relations goals — the more important ones being:—

1. Publicize progress toward high quality medical care.

2. Explain the steps toward wider distribution of medical care.

3. Educate the public in matters of personal health, and promote coöperation of the people and the profession in a constructive health program.

4. To oppose a system of Federal Medicine inimical to the public and to the profession.

5. To investigate all health legislation and report on its value.

6. To bring about public understanding of the basis of medical costs.

7. To encourage physicians to locate in Michigan, particularly in rural communities.

8. To assist in local campaigns to obtain medical facilities.

9. To expose medical rackets.

10. To encourage post-graduate medical study.

11. To urge young men to enter the medical and health professions.

In our Maine Medical Association, I think we would do well to adopt such policies. We have the mechanism for promoting public relations.

We have a high salaried specialist, whose duty among others, I understand, is to keep the County Societies informed about the changes that are creeping into the practice of medicine, as they affect the profession and the public, also that he act as a Public Relations man, under the auspices of a well informed Council of the Maine Medical Association.

Finally it would seem that the most important factor is *Education*, not only of the public, but of the doctor.

If the average physician were asked if he were against the Murray-Wagner-Dingell bill, he would say, "yes," but if asked why, would be unable to tell. It is important that each and every one of us should know why, so we can explain it to the public.

After all the American people will decide what type of medicine is wanted in this United States. We believe that the public should be honestly educated as to how to obtain good medical care when needed.

We believe that the real start in any policy which the State Association may have or wish to engineer, must come from the County Societies, as I have urged in earlier publications of our State JOURNAL.

In conclusion, I would like to quote Dr. Louis Bauer, a member of the Board of Trustees of the American Medical Association.

"A fact that I have stressed many times, and shall continue to stress is, that there should be more interest in the County Societies.

The County Society is not active and the meetings are poorly attended.

It is highly essential that the County Society be the activating force in all these matters; otherwise, we are defeated before we start.

The physician must be the engine in the whole matter, and he needs the backing of his County Society."

We have arrived at the point of diminishing returns for efforts expended in the tuberculosis program—that is, we must work harder to be sure of continued reduction in the death rate. Comm. on Tbc., N. H. Med. Soc., *N. E. Jour. Med.*, Sept. 26, 1946.

*Intracranial Aneurysms**

William J. German, M. D., New Haven, Conn.†

Intracranial aneurysms have an incidence of about one per cent, on the basis of autopsy studies. The most common types are arteriosclerotic and congenital. The former are often multiple, the latter usually single. The congenital type may give rise to symptoms at any age but the peak incidence of symptoms is during the third, fourth and fifth decades. The typical symptomatic onset is in the form of a spontaneous subarachnoid hemorrhage; in fact, when such a dramatic incident occurs an aneurysm should be suspected immediately. The initial hemorrhage may be relatively mild but it is likely to be followed by a second and more severe episode. As each succeeding hemorrhage carries a higher mortality rate, it is essential that the diagnosis be made and treatment instituted as early as possible.

Diagnosis. Since spontaneous subarachnoid hemorrhage is a basis for the presumptive diagnosis of intracranial aneurysm, every effort should be made to localize or lateralize the aneurysm from the neurological signs and symptoms. Symptoms at the onset of hemorrhage such as unilateral pain in the head or face, unilateral visual disturbance, focal sensory or motor symptoms, may give important clues in this respect. Further evidence may be obtained as the result of careful and repeated neurological examinations. Aneurysms of the internal carotid artery not infrequently involve the homolateral third cranial nerve. Thromboses of various portions of the arterial tree distal to the aneurysm are not uncommon, with attendant neurological signs. A ruptured aneurysm in the cavernous portion of the internal carotid artery results in the well-known syndrome of homolateral pulsating exophthalmos with oculomotor palsies and a cranial arterial bruit.

The final step in diagnosis is the roentgen demonstration of the aneurysm by arteriography. Having obtained some diagnostic lead concerning the lateralization of the aneurysm, arteriography should be undertaken on the suspected side. Since 75 per cent of the aneurysms are located in the anterior portion of the circle of Willis or its branches, arteriography is usually done through the internal or common carotid arteries. At present, open exposure of the artery and the use of thorotrast appears advisable. The injection is done rapidly and the roentgen film or films are obtained near the end of the injection. Arteriography is usually unnecessary for the diagnosis of carotid-cavernous sinus fistulous aneurysms. Vertebral arteriography is still in the exploratory stage. Arteriography should be preceded by routine roentgenograms of the skull, since calcification of an aneurysm may be occasionally detected.



Arteriogram (thorotrast) demonstrating congenital aneurysm of internal carotid artery.

Treatment. Aneurysms of the internal carotid artery may be treated by ligation of the internal carotid artery in the neck. The efficiency of collateral circulation in the circle of Willis should be tested by progressive intervals of digital compression of the common carotid artery prior to operation. Further test of collateral circulatory efficiency may be obtained by temporary occlusion of the exposed internal carotid artery immediately after arteriography,

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* Presented at the Cumberland County Medical Society meeting, Portland, Maine, September 27, 1946.

† From the Department of Surgery, Yale University School of Medicine.

Clinico-Pathological Exercise

Case Presented at the Maine General Hospital, Portland, Maine

Edited by Joseph E. Porter, M. D., Portland

This is the case of a 48-year-old white male shipyard worker first admitted to this hospital in 1942 with a chief complaint of swollen, painful left leg of five weeks' duration and painful right leg of one week's duration. He had been in good health until onset of these complaints, although he had noticed occasional mild cramping discomfort in the calves of his legs when on his feet a great deal. From the onset the pain in the left leg was associated with a cramping pain in his calf and followed within 24 hours by a gradual onset of swelling of the leg which first involved the ankle and extended above the knee. There was a distinct feeling of heaviness and discomfort in the leg and aching sensation in the left groin. About one week before admission he began to notice pain in his right thigh, accompanied by very slight swelling of the lower right leg. This became progressively worse. No history of trauma associated with present illness. Patient smoked several packages of cigarettes a day and used alcohol moderately.

Past History: General health good. No history of tuberculosis, typhoid fever, diabetes, nephritis, bleeding tendencies, cardiorespiratory history did show some dyspnea after exertion. Had a slight productive cough of one year's duration. One year previous to admission patient had an episode of acute collapse associated with pain in the chest for which he was hospitalized for an unknown length of time. He was never told the cause of his pain. He habitually used two pillows because of discomfort when lying flat. Family history was non-contributory. Genito-urinary history was essentially negative. Gastro-intestinal history revealed appetite fair, no indigestion or epigastric distress except occasionally following fried foods, no melena, bowels had been slightly constipated.

Physical Examination: Temperature 98.4 degrees, pulse 84, respirations 22, blood pressure 90/55. Physical examination revealed a thin, rather wiry male who did not appear acutely ill. Essential findings: teeth were carious with pyorrhea, throat was slightly infected, no lymphadenopathy. Thyroid not palpable. Lungs were clear to percussion and auscultation. Apical impulse in midclavicular line, sounds regular and of good quality, no murmurs. Moderate thickening of the radial and brachial vessels. Abdomen soft, no scars or evidence of hernia. Dullness about 3 centimeters below costal margin with suggested liver edge, no other masses were felt. No bone or joint abnormalities. Deep tendon reflexes were present and equal. Legs: with bed rest both legs showed very slight cyanosis over lower two-thirds, bilateral superficial prominence of superficial veins, no pitting edema. Neither dorsalis pedis or posterior tibialis could be made out. The lower third of both legs were slightly cool and slightly moist, no tenderness in the calf or thigh of left leg, tenderness over medial aspect of right thigh extending up to Poupart's ligament, tenderness over Hunner's canal and great vein. When elevated both legs blanched in one minute, while dependent both legs became cyanotic within one and one-half minutes. Femoral pulsations were present bilaterally. Popliteal pulses were palpable but slightly diminished. Rectal examination not remarkable.

Laboratory: Initial urine examination: Alkaline, Sp. Gr. 1.018, occasional white blood cell, urine chemistry negative. Admission blood sugar 103 mg.%, urea nitrogen 20 mg.%, RBC-6,300,000, 103% hemoglobin, or 18.8 gms., WBC-13,000 with 72% polys, 4% eosinophils, 8% lymphocytes, 5% mononcytes, RBC-essentially normal. Repeat blood count on the following day was essentially the same, the hematocrit being 67.5. Stool was semi-formed, reddish-brown, had a foul odor, occult blood present.

On the second hospital day a paravertebral nerve block was carried out, opposite L-2 and L-4 vertebrae, which failed to show any significant elevation of temperature on the left. There was a slight drop on the right. This was followed

by definite relief in pain in the right thigh. On the fourth hospital day he was bled 400 c.c. of blood and he was bled one pint every other day until a total of 2½ quarts had been removed. On the thirteenth hospital day the patient was much improved, slight tenderness and minimal swelling over the right lower leg, he was up and about with an Ace bandage. At this time the RBC had dropped to 5,190,000, hemoglobin 104%. Patient was bled another 500 c.c. Following this the RBC was 4,630,000 and hemoglobin 90%. He was feeling quite normal and was discharged at this time.

He was readmitted approximately four years later complaining of pain in the right leg and right flank of several weeks' duration and swelling of the right leg of one week duration. He was having some precordial pain following exercise, but the history did not give details. The pain in the leg was definitely aggravated by activity. He had had several phlebotomies since discharge, but none for over a year. He was complaining of shortness of breath on exertion, slight cough, no hemoptysis, had a rather poor appetite of late and had some urinary frequency.

Physical examination at this time revealed pigmentation over both tibias and cyanosis of feet. There seemed to be some increase in fluid in the right knee joint, no limitation of motion. Pain over L-1 and L-2. At this time the RBC was 6,210,000, hemoglobin 118%, hematocrit 60. Kahn and Hinton were negative. Patient had one phlebotomy on the fourth hospital day. Following this the RBC was 6,200,000, hemoglobin-10%.

Approximately two months later the patient was again admitted because of severe constant abdominal pain. Since last admission he had been working in the ironworks and felt fairly well. About one week before admission he began to have severe constant abdominal pain. He was hospitalized in another hospital where he received Penicillin and hypos for pain. He had lost 12 pounds.

Physical Examination showed blood pressure 120/85, pulse 100, temperature 98.6. It showed an apprehensive male who appeared to have considerable pain. Abdomen was very rigid with tenderness in the right upper quadrant and right costa-vertebral angle, marked rigidity on palpation, "considerable distension and visible peristalsis." RBC at this time was 5,190,000, hemoglobin-104%. Stool was negative for occult blood. Urine showed 45 mg. of albumin, with 1-2 rbc, Sp. Gr. 1.015.

The day after admission K. U. B. X-ray showed considerable gas in the large bowel, kidney shadows were obscured, and there was considerable sclerosis of the iliac vessels. Intravenous pyelogram showed good prompt excretion on both sides. There was some distortion seen in the pelvis on both sides, but this was thought to be insignificant. Patient had 1500 c.c. of blood removed by phlebotomy, on the sixth hospital day the hemoglobin was 72%. Gastro-intestinal series was done on the fourth hospital day which showed constant irregularity in the duodenum and flecks of barium in central portion. A six-hour film revealed marked dilatation of small bowel on the left side. In area of jejunum there was a clean-cut, circular defect measuring about 16 x 20 m.m. in diameter very suggestive of a tumor mass. Beyond this point the small bowel was not dilated, in 24 hours a large amount of barium was still in the stomach, still considerable dilatation of the jejunum. Some barium, however, was in the cecum and splenic flexure.

On the eight hospital day a Miller-Abbott tube was inserted. On the ninth hospital day temperature was 102.4 degrees rectally. Patient seemed to be getting worse, and operation was elected. Following operation heart rate became irregular, patient was digitalized. His course was steadily downhill and he expired on the second post-operative day, eleventh hospital day.

Discussion

Dr. Elton Blaisdell: First let us see what we have, a man aged 48 years, who in 1942 thought he was in good health until five weeks before admission, although one year previously he had had an acute episode of chest pain associated with collapse and for several months had had cramps in both legs on walking. His chief complaint on admission was a painful, swollen left leg of five weeks' duration and a painful right leg of one week duration.

On physical examination no apparent cardiac disease was illicited. The blood pressure was 90/55. The chest seemed to be normal. There was moderate thickening of the radial and

brachial arteries. The liver was enlarged 3 centimeters below the costal margin. There was bilateral prominence of the superficial veins of both legs. Neither dorsalis pedis or posterior tibialis could be felt. Both feet and legs quickly became cyanotic on suspension. There was tenderness over the medial aspect of the right thigh. There was no tenderness in the calf of either leg. The blood count showed hemoglobin 130%, RBC-6,300,000, WBC-13,000 with 72% polys, 5% eosinophils, 8% lymphocytes, and 5% monocytes. The RBC was essentially normal. The hematocrit reading was 67.5 (remember this was still 60—four years later).

On the second hospital day a paravertebral nerve block was done, this failed to show any significant elevation of temperature on the left and there was a slight drop on the right. He was bled several times—2900 c.c. in all, in about two weeks and then discharged feeling quite well with only slight tenderness in both legs.

The patient was readmitted four years later with a chief complaint of pain in the right leg and right flank of several weeks' duration. He also had had some precordial pain on exertion but an accurate history of this difficulty is not obtainable from the record. Several phlebotomies had been done since the last admission but not for the past year and his blood count on this admission was: hemoglobin 11%, RBC 6,210,000, WBC not recorded, hematocrit 60—still above normal. There was negative serology. The patient was bled from the fourth hospital day and soon after discharge apparently feeling much better. It should be noted that on this admission a skin rash was discovered over both legs.

For a short time the patient worked in the ironworks but was admitted here again two months later for the third time. One week before this admission he began to experience severe abdominal pain. The abdomen was very rigid, and the temperature was 98.6, hemoglobin 104%, RBC 5,190,000, but for some reason the WBC is omitted in the history at this point. It is well known that leukemia not infrequently may be present in patients who have had a certain disease which is characterized by a high red count, elevated hematocrit, and increased red cell mass.

Dr. Porter: On second admission the WBC was 7,800.

Dr. Blaisdell: Dr. Spencer, will you please show us the X-rays?

Dr. Spencer: The intravenous pyelogram shows normal kidneys. There are gas outlines in the transverse colon with some small bowel gas in the first plate and the second taken three days later, the patient had had an upper gastrointestinal examination. The A-P view shows some barium in the jejunum. The plates taken six hours after ingestion of the barium shows definite obstruction blocking the pylorus. The picture taken during fluoroscopy showed marked deformity in the region of the duodenum. Two hours after the barium, examination shows the dilated cecum and jejunum with an apparent narrowing at this point and twenty-four hours after barium meal you have some barium passing into the colon and segments of dilated bowel. This film was taken two days after or 72 hours after barium meal and he still has barium in the small bowel and in the small intestine. From the X-rays I think that we have

FIGURE 1.



Figure 1. Roentgenogram taken 72 hours after ingestion of barium meal.

Some of the barium can still be seen in the colon. The small intestines are dilated and still contain some barium.

In the left upper abdomen the "coil spring" Kerkring's folds identifies this segment as jejunum. In the lower abdomen the square-like Kerkring's folds identifies this as the terminal ileum indicating the obstruction is at this level.

demonstrated a deformity of the duodenal cap and small bowel obstruction.

Dr. Thompson: Where is the circular defect described in the X-ray report?

Dr. Spencer: I do not see it, the only thing I see is a midbowel obstruction.

Dr. I. Webber: Is it suggestive of a polypoid tumor?

Dr. Spencer: I think I would hesitate in saying that it was a polypoid tumor. I should say a small bowel obstruction.

Dr. Blaisdell: Thank you very much, Dr. Spencer, and on the day after this last admission a K. U. B. plate showed considerable gas in the large bowel. An intravenous pyelogram was thought to be normal. There was marked sclerosis of the iliac vessels. A gastro-intestinal series was done. This showed evidence of a duodenal ulcer, stasis in the stomach, dilatation of the small bowel on the left, and a defect 6 x 20 m.m. in diameter in the jejunum very suggestive of a tumor. On the eighth hospital day the temperature rose to 102.4 and he was operated on following which his heart became irregular and he died on the eleventh hospital day. Now let us list what we have as diagnostic signs:

1. A man in his early 50's with advanced vascular disease.

2. Temporary bouts of phlebitis.

3. Some evidence of coronary disease but very little in the clinical findings to enable us to make a definite diagnosis.

4. An elevated RBC of 6,200,000 with a hemoglobin of 130% and as far as is known a hematocrit reading of always around 60%. That is, the hematocrit reading was always increased.

5. The red cell mass was not reported, this, of course, would be very helpful.

6. An enlarged liver.

7. Skin rash on legs.

8. Duodenal ulcer but it is well to remember here that this condition is 2½ times as common in Polycythemia vera as found in the average patients.

9. An acute abdominal complication resulting in his death.

10. I think we should also include a negative stool finding in the last admission.

Is there any one disease in which one can have all these things? Of course, the answer is yes, but one must not forget that more than one disease can exist in one patient. It seems rather easy to me, perhaps too easy, to explain all of these findings on one disease—up to the bowel defect. The X-ray interpretation is more difficult to link up with the same condition.

For a moment let us forget the acute abdominal episode and what condition or conditions we could consider that could possibly be responsible for some of these findings. First, Buerger's disease—In Buerger's disease there may be at times a slight increase in the red cell count but practically never above 5,400,000, also the hematocrit may be slightly elevated but very rarely above 50. In Buerger's disease calcification of the vessels is very rare. Peptic ulcer which is found in this patient is not a common finding in Buerger's disease.

Second—Periarteritis nodosa should be considered in all patients with obscure vascular changes but in this condition anemia is frequently present as well as a history of bouts of acute chest complications with eosinophilia — not uncommonly to be followed by death from renal insufficiency.

Three—Endarteritis obliteritis, should, of course, be considered as the patient certainly had this but I believe it was secondary to some other disease, otherwise, how could we explain the increased RBC and hematocrit especially in the absence of chronic pulmonary disease. The rather low blood pressure gives us no leads.

Now as to my diagnosis—it seems to me that Polycythemia vera even though the RBC was never over 6,500,000 can readily explain all the symptoms and findings except possibly the acute episode in the last days of life. As far as I know Polycythemia vera is the only disease that could account for the following findings which we have here.

Dr. Blaisdell's Diagnoses

1. Advanced arterial disease with thrombosis.

2. Phlebitis.

3. Increased RBC, hemoglobin, and hematocrit.

4. Duodenal ulcer.

5. Skin rash.

6. Enlarged liver.

7. An acute abdominal crisis presumably due to thrombosis of some of the mesenteric vessels (one would, of course, like to hear mentioned a palpable spleen, but this is not necessary).

Dr. Blaisdell: I believe the mesenteric thrombosis with infarct in the jejunum was the cause of the partial small bowel obstruction. Perhaps if I were conservative I might leave the question of tumor in the jejunum to stand as the X-ray suspected. However, I will say that I believe this to be impossible with the data as we have it, and I will stick to my original diagnosis.

Dr. Porter: In answer to your request about the red cell mass. This was found to be 89 c.c./kg. and was reduced to 40c.c. after phlebotomy.

Anatomical Diagnoses

Mesenteric venous thrombosis.

Surgical anstamosis of ileum.

Focal peritonitis.

Healed duodenal ulcer.

Generalized arteriosclerosis.

Dr. Porter: This patient died as a result of occlusion of the superior mesenteric vein. He had been operated because of gangrene of his small bowel which had been resected. There was a progression of the necrotic process which the surgeon was not aware of at the time of operation. He had severe, atherosclerosis. The lantern slides showed very nicely what we felt represented a healed duodenal ulcer. There was no tumor found in the small bowel. I know of no way to make an anatomical or microscopic diagnosis of Polycythemia vera. There was nothing found at autopsy which one could attribute as an etiologic agent for Polycythemia vera. An examination of the bone marrow failed to reveal any pronounced degree of sclerosis of the capillaries, similar to that described by Reznikoff, Foot, and Bethea[1]—the bone marrow was very cellular and there was only a slight appreciable increase in the cells of which there were more immature than normal blasts, and neither was there any evidences of extramedually, hemopoeisis demonstrated. The spleen weighed 100 grams.

Dr. I. Webber: You would say that the bowel had been incompletely removed?

Dr. Porter: There was a good deal of gangrenous bowel present at the time of autopsy, however, as I mentioned previously there could very well have been a retrograde progression of thrombotic processes. It would seem to me that if the superior mesenteric vein had been occluded at the point where we saw it at autopsy the surgeon would have found more extensive gangrene of the small bowel at the time of operation.

Dr. Glassmire: Was any other form of therapy used to lower this man's blood pressure?

Dr. Porter: No.

Dr. Broggi: I recently heard of the use of radio-active phosphorus in the treatment of this condition. I wonder if Dr. Spencer could say a few words concerning its use.

Dr. Spencer: Radio-active phosphorous has been used. Limiting factor in the treatment of Polycythemia vera is the amount of radiation the bone marrow will tolerate, that is, when treated with spray X-ray therapy. The entire body is treated. The daily dose of radiation varies from 12½ to 25r measured in air. The platelet count and white cell count is carefully followed. Often the treatment is interrupted to evaluate the degree of destruction of the red cells. The total amount given varies from a minimum of 200r to a maximum of about 600r.

Dr. Porter: With respect to treatment I would like to call your attention to the work of Schafer[2] who emphasized the neuro-vascular systems relationship to Polycythemia vera and was able to produce definite lowering of the RBC in one patient suffering from Polycythemia vera by an extensive lumbo-dorsal sympathectomy.

Dr. Blaisdell: In Germany in the early '30's it was thought that there were two types of Polycythemia vera—one associated with hypertension and one without.

Dr.Geyerhahn: Was any form of anti-coagulant used?

Dr. Porter: No.

Dr. Geyerhahn Why was not an anti-coagulant used?

Dr. Parker: This patient was operated upon while in desperate condition with a tentative

1. *Am. J. M. Sc.*, 189:753, 1935.

2. Schafer, P. W., *Annals of Surgery*, 122; 1098, December, 1945.

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The President's Page

I recently attended the Summer meeting of the Piscataquis County Society at Squaw Mountain Inn, Moosehead Lake. They sponsor annually this meeting to which are invited the Doctors of Aroostook, Penobscot, Somerset and Kennebec Counties. They always have a fine get-together. The attraction this year was a paper on "The RH Factor—Its Clinical Application." Believe it or not, the women (Doctors' wives and guests) outnumbered the men, and there was a large attendance of the latter. In small groups, we not only talked about the RH Factor and Socialized Medicine, but also about Prepayment Insurance, Cancer Drives, Nursing Problems, Community Hospitals and Clinics, and what can be done for the General Practitioner. The meeting will be written up in the JOURNAL. This is what I want to get across; attendance at your County Meetings is sure to pay you dividends over and above the time lost from your practice. Just getting out to talk to, and ask questions of, your confreres will keep you out of the rut.

There was a time that you and I would stay home from a Local or County Medical Society Meeting saying we didn't want to waste time listening to a dry Scientific paper that we could read later in the JOURNAL. I am sure we cannot afford to stay away any longer. We are now in Politics up to our necks whether we like it or not. If it had not been for a few far-sighted members of our Profession, State Medicine would have been slipped over on us. From now on, all health and welfare economic problems are ours to solve. If we don't laymen are going to do it for us. That means regimentation and I am sure you don't want that.

Attend your Society meetings—take an active part in their proceedings. Bring up medical problems and discuss them. Encourage the younger men to write papers, and hold office. Our JOURNAL needs a lot of revamping, and our Society needs a lot of new blood in action. Elect delegates from your County Society to the State meetings, who will promise to attend and have constructive action or criticism to offer.

Write your Councilor, or the Chairman of the Program Committee, what you desire to hear at your meetings.

It is your Society.

STEPHEN A. COBB, M. D.,
President, Maine Medical Association.

Editorial

The American Medical Association — Its Origin and Growth — 1847-1947

Nineteen hundred and forty-seven marks the centennial year of the American Medical Association.

On May 5, 1847, delegates to the National Medical Convention met in the hall of the Academy of Natural Sciences in Philadelphia and founded the American Medical Association.

Several names were first suggested for this new permanent national association of physicians, including "The Conventional Association of the United States," and "The Medical Association of the United States of North America." Both these proposals were lost on the convention floor, after which the constitution was offered and accepted. The constitution included the clause "This institution shall be known and distinguished by the name and title of the American Medical Association.'

The first president was Dr. Nathaniel Chapman, of Pennsylvania.

A. M. A. Prosecutes War on Quackery

From the very beginning the American Medical Association has prosecuted its war on quackery and more than any other agency in the country can take the credit for the vast improvement that has occurred in the abolition of nostrums, secret medicines and quackery. At the session on May 7, 1847, Dr. John B. Johnson of Missouri introduced a resolution in which he pointed out that numerous and important evils result from the universal practice of allowing persons almost wholly ignorant to engage in apothecaries and still greater from the universal traffic of secret medicines. He urged that schools of pharmacy be established in the individual states and that some rule be adopted that no physician patronize a druggist or apothecary who deals in "patent" or secret medicines.

The delegates who attended that historic meeting numbered 250 and represented more than 40 medical societies and 28 colleges, embracing medical institutions in 22 states and in the District of Columbia.

Association has 131,590 Members

Today the association has 131,590 members and 72,243 Fellows. Members in good standing in the constituent medical associations of the states become automatically members of the American Medical Association. They do not pay any dues or contribute financially to the association. Members may apply for Fellowship, and if qualified pay Fellowship dues and subscribe for *The Journal*.

The association is organized along much the same lines as our government, that is, it is a democratic organization. The cornerstone of the association is the county medical society, of which there are more than 2,000, known in various parts of the country as county societies, parish societies or district societies. The county societies in a state make up the state society. The association is thus seen to be a federation of constituent state societies which in turn are made up of component county or district societies. The policies of the A. M. A. are determined in the last analysis by the House of Delegates, deriving its power from the state societies, which in turn derive their authority from the local membership. The national officers and employees of the association work under the direction of the Board of Trustees, elected by the House of Delegates.

Medical Advancements Helped to Build A. M. A.

The prodigious advancements in medical science during the last 100 years helped to build the American Medical Association, which educates its members through meetings, exhibits, its many periodicals, its councils and committees and in many other ways. The benefits of all these activities are passed on to the public —the ultimate consumer.

The A. M. A. is a non-profit institution. Its purposes are to promote the science and art of medicine; to organize the medical profession and safeguard its interests; to elevate the standard of medical education and practice; to bring about the enactment of uniform legislation for

the public welfare and to protect the public health.

A. M. A. Develops Many Activities

The A. M. A. has in the course of time developed a large number of activities, all of which directly or indirectly react to the benefit of the public health.

In 1873, the Judicial Council of the association was first organized to deal with matters concerning professional ethics. It is not generally realized that the ethical standards which have been maintained and defended by the medical profession throughout the centuries have been and remain among the greatest safeguards to the public health in that they tend constantly to improve the quality of medical practice, to discourage dishonesty, charlatanism, quackery, undue personal ambition, destructive competition, commercialism and other undesirable influences.

In 1883, *The Journal of the American Medical Association* was established. This journal, published weekly, with a circulation in excess of 120,000, is now acknowledged to be the leading medical journal in the world. It is the official spokesman for the organized medical profession of the United States. In addition to *The Journal,* the American Medical Association publishes monthly journals dealing with the following subjects: internal medicine, diseases of children, neurology and psychiatry, surgery, dermatology and syphilology, otolaryngology, pathology, ophthalmology and occupational medicine. These were established at various times between 1909 and 1945.

In 1899, the American Medical Association established its scientific exhibit which has now grown until it furnishes what is probably the outstanding feature of the annual Scientific Assembly and is probably not surpassed by any scientific exhibit anywhere. The Council on Scientific Assembly was established in 1915 to take charge of the annual Scientific Assembly, including the Scientific Exhibit. This offers to the medical profession of America a rich and varied scientific program and through the benefits conferred upon physicians, it reacts in ever widening circles to the benefit of the patients of those doctors.

In 1904, the Council on Medical Education and Hospitals began its work of conducting a clearing house for information concerning medical education and hospitals. The classifications of medical schools and of hospitals have resulted in putting medical education in the United States on a very high plane. There are at present 77 recognized Class A medical schools in the United States and 10 in Canada. Very few inferior schools are able to operate because students naturally choose good schools if they are informed about them. Hospitals are also classified with respect to their acceptability for internship and for residences and fellowships in specialties.

Council on Pharmacy Organized in 1905

The Council on Pharmacy and Chemistry was organized in 1905 to investigate and report on medicinal products offered to physicians for their use. Through this council numerous investigations have been made and reports published in *The Journal.* Since 1909, the council has published annual volumes on proprietary medicinal preparations which enable physicians to know what drugs they are prescribing and the character of proprietary preparations which are offered them. In 1906, a Chemical Laboratory was established as an adjunct to the Council on Pharmacy and Chemistry.

The laboratory staff works amid an intricate array of tubes, retorts, distillers and glistening meters and dials. Grist for the mill is new drugs, covering the Rx range from analgesics to vitamins. Approximately 150 preparations—pills, capsules, powders, liquids—pass through the laboratory each year. Most of them are not intended for over-the-counter sale, but for use on prescription by doctors.

The laboratory, located in the A. M. A. headquarters building in Chicago, aims at giving manufactures an evaluation of their new products, at guiding physicians and protecting the public.

A drug maker — if he chooses — sends in a new specimen, along with detailed data on its name, nature, preparation and use and evidence to support his claims. The sample goes to the laboratory for chemical examination. A report, including an analysis and a finding of "satisfactory" or "unsatisfactory," is sent to the council.

Investigation is begun by the council, too. There are 18 members, all scientists and most of them medical men, each an expert in a particular line.

If the material is approved, the firm receives a shield-shaped emblem letter "Accepted — American Medical Assn. — Council on Pharmacy and Chemistry." If the medicine fails, the company gets an explanation and an opportunity to correct the formula.

The council has card index files on more than 70,000 drug items and access to many thousands of others.

The investigation is free. The A. M. A. underwrites all expenses and regards the money well spent. Coöperation between manufacturers and the agency has helped reduce the flow of questionable drugs. Less than one per cent of the specimens submitted nowadays are rejected.

Work of the Bureau of Investigation

The association established a Bureau of Investigation in 1906 to gather information on the nostrum evil and quackery, medical frauds, fallacies, faddism and allied topics. This material is published from time to time in *The Journal* and has been compiled into two volumes entitled Nostrums and Quackery, as well as numerous pamphlets dealing with such groups of preparations as fake obesity cures, mechanical nostrums, mail order frauds, deafness cures and other forms of frauds.

The Bureau of Investigation is a clearing house for information on subjects with which it deals. Federal, state and municipal health officials, teachers in schools and colleges, physicians and others interested in the public health refer thousands of inquiries to this bureau each year. The functions of the bureau are wholly educational in character—not punitive.

The American Medical Directory was begun in 1906. It is a central listing of all physicians known to the American Medical Association, including interns and residents in hospitals. Non-members as well as members are included in the directory. The directory is ordinarily published every two years, but was postponed during the war. Data in the directory includes information as to the physician's date of birth, his medical education, year of license, membership and fellowship in the American Medical Association, membership in other medical associations and his connections, if any, with medical education. The directory also lists hospitals and allied institutions.

In 1911, long before health education was a popular subject, the American Medical Association established a Council on Health and Public Instruction, which was renamed the Bureau of Health Education in 1938. The purpose of the bureau is to promote popular understanding of health and the relation of medicine to the public health through such media as *Hygeia,* The Health Magazine, pamphlet publications, radio talks, coöperative advisory relationships with lay organizations interested in health education, health exhibits, personal addresses by the director, and by furnishing material for activities in health education to state, county and district medical organizations.

Sponsors Extensive Radio Programs

The American Medical Association through the Bureau of Health Education has, since 1935, developed extensive programs of radio health dramas. Continuously from 1935 to 1947 the association has broadcast on a nationwide network of the National Broadcasting Company. Since 1943, a library of radio transcriptions in interview and dramatic form has been established for loan to local health or civic agencies.

In 1910, the American Medical Association library was established, through which doctors can borrow packages of clippings or single issues of medical periodicals. This service brings the latest scientific information within reach of the remotest doctor who is a member of the association or a subscriber to *The Journal.*

Another part of the service of the library of the American Medical Association is maintenance of the Quarterly Cumulative Index Medicus, which was taken over by the American Medical Association in 1915 and has been published ever since at a substantial annual loss to the association. It offers physicians in America an index to all significant medical literature in every language.

The Bureau of Legal Medicine and Legislation was established in 1922. Through this bureau the medical profession is kept informed of legislative proposals and the legislators in turn may be advised as to the opinion of physicians on legislation affecting the public health.

A. M. A. Publishes National Health Magazine

In 1923, the American Medical Association launched a project which has proved to be unique, namely, a magazine of national circulation devoted exclusively to authoritative material on health and health education. The magazine was appropriately named *Hygeia*. It is dedicated to the purpose of enlightening the public with relation to health and medical matters and it represents the conviction of the medical profession that the public is entitled to such knowledge about health as can profitably be acquired by non-medical persons.

The Council on Physical Medicine was established in 1925 and the Council on Foods and Nutrition in 1929. These are similar in character to the Council on Pharmacy and Chemistry, but they deal, respectively, with methods and appliances in physical therapy and with foods. The influence of such councils and committees is to discourage exploitation of the public by those who would foist upon them or upon the profession methods, apparatus or products which are advertised with claims that cannot be substantiated.

The Council on Industrial Health was established in 1938 to deal, as its name indicates, with medical and health problems in industry and with the health of industrial workers.

The Council on Medical Service was established in 1944 to develop ways and means of supplying the American people with adequate medical service.

The Bureau of Medical Economic Research was established in 1931 to study the economic aspects of the practice of medicine in the United States, which covers the supply of and the demand for medical service.

The activities of the American Medical Association are directed through two principal channels, namely, to the profession and to the public. Its service to the profession is all calculated to raise the standards of medical practice, keep the profession free from contamination by selfish interests and enable it to serve the public better. Anything that improves medical practice is an important fundamental necessity for the public health. In addition, the association from its national headquarters and through many of its state and county societies is rendering direct educational service to the public.

10-Point National Health Program

From the standpoint of public health, the physicians of the United States, through the American Medical Association, have long advocated a national health program which would extend to all people in all communities the best possible medical care. Following is the association's constructive 10-point program for the extension of improved health and medical care to all people:

1. Minimum standards of nutrition, housing, clothing and recreation are fundamental to good health.

2. Preventive medical services should be available to all and should be rendered through professionally competent health departments. Medical care to those unable to provide for themselves should be administered by local and private agencies with the aid of public funds when needed, preferably by a physician of the patient's choice.

3. Adequate prenatal and maternity care should be made available to all mothers. Public funds when needed should be administered by local and private agencies.

4. Every child should have proper attention, including scientific nutrition, immunization and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child health centers administered locally with support by tax funds whenever the need can be shown.

5. Health and diagnostic centers and hospitals necessary to community needs are preferably supplied by local agencies. When such facilities are unavailable, aid may be provided by federal funds under a plan similar to the provisions of the Hill-Burton bill.

6. Voluntary health insurance for hospitalization and medical care is approved, the principles of such insurance plans to be acceptable to the Council on Medical Service and to authoritative bodies of state medical associations.

7. Medical care, including hospitalization, to all veterans should be provided preferably by a physician of the veteran's choice, with payment through a plan agreed on between the state

medical association and the veterans' administration.

8. Research for the advancement of medical science, including a national science foundation, is endorsed.

9. Services rendered by volunteer philanthropic health agencies should be encouraged.

10. Widespread education in the field of health, and the widest possible dissemination of information regarding the prevention of disease and its treatment, are necessary functions of all departments of public health, medical associations and school authorities.

Probably no greater mental trauma is ever inflicted by a physician than when he first tells a patient that he or she has tuberculosis. The patient probably knows absolutely nothing about tuberculosis except that it is a dread disease. Material and social problems combined with the psychological problems of separation from family, complete change of living routine, sudden cessation of all activity, ignorance of the disease and what it will mean to him and an unknown future is apt to create in the patient a mental turmoil which is a known detriment to his eventual recovery and return to a useful life. C. J. Stringer, M. D., *Hospitals*, August, 1946.

When compared with some other diseases, the purchase price of control of tuberculosis may be considered a bargain. This is so because we know its cause. We know how it is spread. We know how to prevent it, and we know how to treat it. Moreover, it costs pennies to control it, and dollars to tolerate it. Robert E. Plunkett, M. D., N. Y. Dept. of Health, Mar., 1946.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine Eye and Ear Infirmary Maine General Mercy	1st Wednesday 2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

COUNTY SOCIETIES

Androscoggin
President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, Edward A. Greco, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Maynard B. Colley, M. D., Wilton
Secretary, Kenneth A. LaTourette, M. D., Farmington

Hancock
President, Raymond E. Weymouth, M. D., Bar Harbor
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Frank B. Bull, M. D., Gardiner
Secretary, Arch H. Morrell, M. D., Augusta

Knox
President, Wesley N. Wasgatt, M. D., Rockland
Secretary, Freeman F. Brown, Jr., M. D., Rockland

Lincoln-Sagadahoc
President, Stanley R. Lenfest, M. D., Waldoboro
Secretary, John F. Dougherty, M. D., Bath

Oxford
President, Walter G. Dixon, M. D., Norway
Secretary, Dexter E. Elsemore, M. D., Dixfield

Penobscot
President, Edward L. Herlihy, M. D., Bangor
Secretary, John E. Smith, M. D., Bangor

Piscataquis
President, John B. Valentine, M. D., Dover-Foxcroft
Secretary, Norman H. Nickerson, M. D., Greenville

Somerset
President, Richard P. Laney, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Seth H. Read, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

Piscataquis

A meeting of the Piscataquis County Medical Association to which the members of the Aroostook, Kennebec, Penobscot, and Somerset County Societies were invited was held at Squaw Mountain Inn, Greenville, Maine, July 24, 1947, at 3.00 P. M.

J. Neber, M. D., of the New England Medical Center, Boston, gave an excellent talk on "The Clinical Significance of the Rh Factor."

A social hour was enjoyed, following which dinner was served to 68 members and guests. Stephen A. Cobb, M. D., President of the Maine Medical Association, gave an interesting talk on the English Panel System of Socialized Medicine as he observed it during his two and one-half years in England.

N. H. Nickerson, M. D.,
Secretary.

Coming Meetings

Cumberland County Medical Society

August 28, 1947, at the Portland Country Club, Portland, Maine.

Dinner: 6.00 P. M.

Speaker: Howard Karsner, M. D., Cleveland, Ohio.

Subject: Disseminated Lupus Erythemotosis.

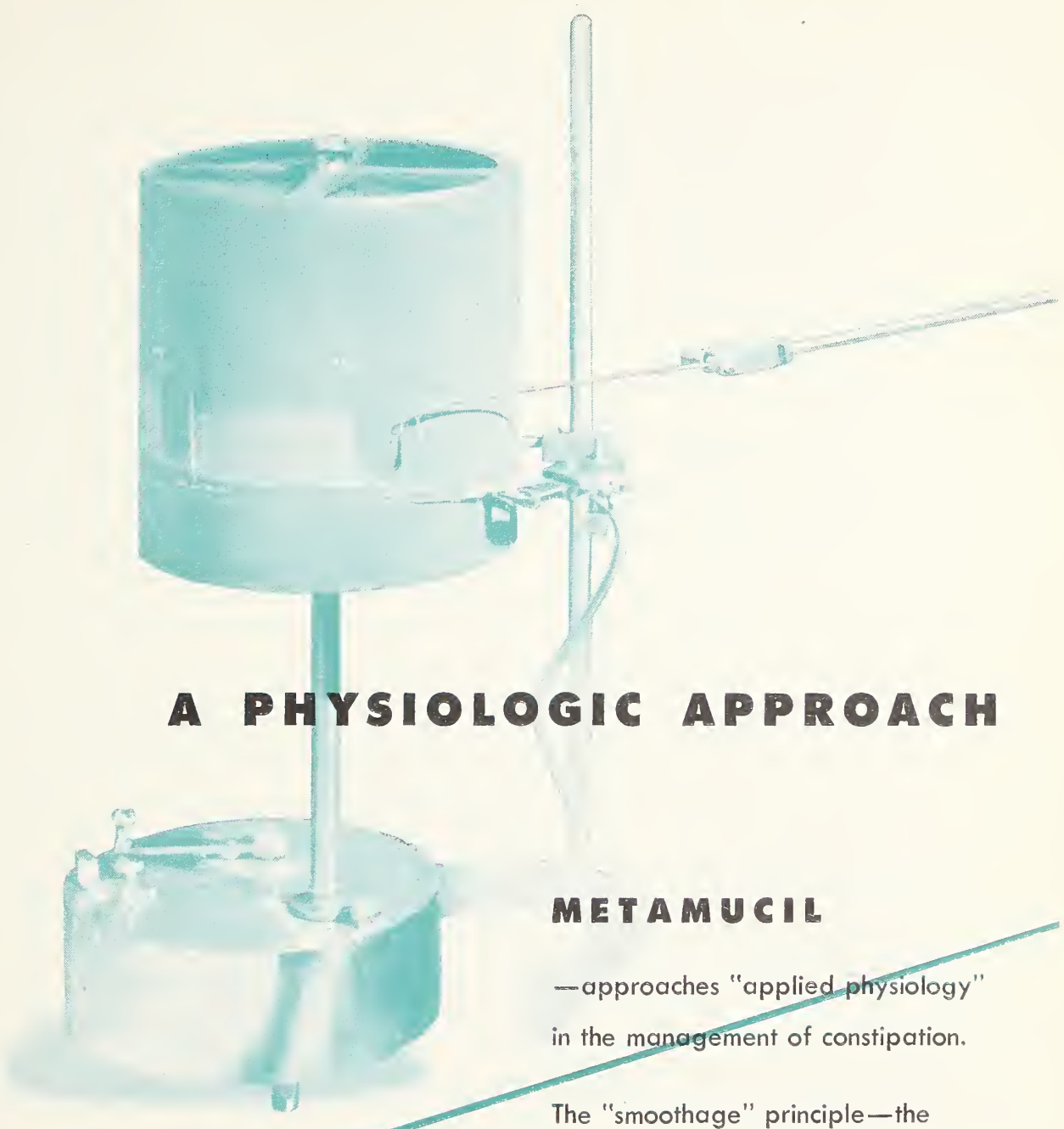
News and Notices

Adam P. Leighton, M. D., Elected to Membership National Board of Medical Examiners

The Federation of State Medical Boards of the United States has been officially notified that Dr. Adam P. Leighton of Portland, Me., was unanimously elected a member of the National Board of Medical Examiners at its annual meeting on June 7. He was elected on nomination by the Federation and succeeds the late Dr. Osborn, and will therefore fill the balance of his term, which would have expired in 1949. At that time Dr. Leighton will of course be eligible for election to a full term.

Adam P. Leighton, M. D., of Portland, has recently returned from a trip to England, France, and Ireland, during which he attended the International Congress of Obstetricians and Gynaecologists, which was held at The Royal College of Surgeons, Dublin, Ireland, to celebrate the Bicentenary of the Rotunda Hospital.

Continued on page 204



A PHYSIOLOGIC APPROACH

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Henry F. Smith, M. D., To Locate In Jackman

Henry F. Smith, M. D., recently discharged from the U. S. Navy, after having served as a Flight Surgeon for five years, is to locate in Jackman, Maine.

Dr. Smith was graduated from the College of Physicians and Surgeons of Columbia University in 1938. He practiced in New York for two and one-half years previous to enlisting in the Navy.

He is married and has two children.

David H. Stevens, New Health and Welfare Commissioner, Confirmed by Executive Council

David H. Stevens officially became Commissioner of the State Department of Health and Welfare, July 30th, when his nomination by Governor Horace H. Hildreth was confirmed by the Executive Council.

The new commissioner has been serving in an unofficial capacity at the Department since the resignation of Dr. Leverett D. Bristol, late in June.

Northern Cumberland Hospital Announces Building Fund Chairmen

Chairmen in nine Cumberland County towns were announced July 30th, for the building fund campaign to be held from August 18 to 28 for the proposed New Northern Cumberland Hospital at Bridgton, Maine.

Second Annual Postgraduate Course In Diseases of the Chest

The American College of Chest Physicians is sponsoring a second annual postgraduate course in diseases of the chest to be held during the week of September 15-20, 1947, at the Municipal Tuberculosis Sanitarium, Chicago, Illinois.

The emphasis in this course will be placed on the newer developments in all aspects of diagnosis and treatment of diseases of the chest.

The course will be limited to 30 physicians. Tuition fee is $50.00.

Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Bureau of Health

State Services for Crippled Children Clinic Schedule, 1947

Portland—Children's Hospital, 9.00-11.00 a. m.: Jan. 13, Feb. 10, Mar. 10, Apr. 14, May 12, June 9, July 14, Aug. 11, Sept. 15, Oct. 13, Nov. 10, Dec. 8.

Lewiston—Central Maine General Hospital, 9.00-11.00 a. m.: Jan. 24, Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 29, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Rumford — Community Hospital, 1.30-3.00 p. m.: Apr. 16, June 18, Aug. 20, Oct. 15, Dec. 17.

Waterville—Thayer Hospital, 1.30-3.00 p. m.: Feb. 27, Apr. 24, June 26, Aug. 28, Oct. 23, Dec. 18.

Rockland—Knox County Hospital, 1.30-3.00 p. m.: May 15, Aug. 14, Nov. 13.

Machias—Normal School, 1.30-3.00 p. m.: Apr. 9, July 16, Oct. 22.

Presque Isle — Northern Maine Sanatorium, 9.00-11.00 a. m.: Jan. 7, Mar. 5, May 6, July 9, Sept. 9, Nov. 5.

Houlton — Aroostook General Hospital, 9.00-11.00 a. m.: Mar. 4, July 8, Nov. 4.

Fort Kent — Normal School, 9.00-11.00 a. m.: Jan. 8, May 7, Sept. 10.

Bangor—Eastern Maine General Hospital, 1.30-3.00 p. m.: Mar. 27, May 22, July 24, Sept. 25, Nov. 20.

Portland — Cardiac, Maine General Hospital, 10.00-12.00 a. m.: Will be held every Friday with the exception of holidays (May 30, July 4, and Dec. 26).

State Pediatric Clinic Schedule, 1947

Bangor — Eastern Maine General Hospital, 1.30 p. m.: Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 22, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Waterville — Thayer Hospital, 1.30 p. m.: Jan. 7, Mar. 4, Apr. 1, May 6, June 3, July 1, Aug. 5, Sept. 2, Oct. 7, Nov. 4, Dec. 2.

Presque Isle — Northern Maine Sanatorium, 1.30 p. m.: Mar. 26, May 21, July 23, Sept. 24, Nov. 19.

Clinic visits by appointment only. Referrals may be sent to: Division of Services for Crippled Children or Division of Maternal and Child Health, State Bureau of Health, Augusta, Maine.

Continued on page 206

WHY DON'T YOU GET YOUR PAY?

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Necrologies

Louis N. Ellingwood, M. D., 1855-1947

Louis N. Ellingwood, M. D., 91, died July 6, 1947, at his home in Skowhegan, Maine.

Doctor Ellingwood was born in Swanville, Maine, October 26, 1855, the son of Joseph and Bianca Hartford Ellingwood.

He was graduated from the University of Pennsylvania in 1878, and from the Eclectic Medical College, Cincinnati, Ohio, in 1884, following which he located at Athens, Maine. He later attended the New York University Medical College, was graduated in 1893, and returned to Athens to resume practice. He retired in 1944. During his long service in Maine he was also located at Bridgton four years and at Skowhegan one year.

He was an Honorary Member of the Somerset County Medical Society and the Maine Medical Association, and a member of the American Medical Association.

In addition to the 50-year medal presented to him by the Maine Medical Association in 1931, he had received a 50-year Masonic jewel from Keystone Lodge of Solon, and a 60-year Odd Fellows jewel from Wesserunsett Lodge, IOOF, of Athens.

He is survived by his widow, Mrs. Ella Parsons Ellingwood, whom he married in 1887.

Ralph W. Goss, M. D., 1879-1947

Ralph W. Goss, M. D., 68, died at his home in Litchfield, Maine, July 16, 1947.

A native of Lewiston, he was graduated from Nichols Latin School and Bates College in that City, and received his medical degree from Bowdoin Medical College in 1904. He interned at the Portland Eye and Ear Infirmary and Togus Veterans' Hospital, and began his practice in Litchfield in 1905.

He is survived by his widow, Mrs. Emma Dickson Goss.

Paul S. Hill, Sr., M. D., 1881-1947

Paul S. Hill, Sr., M. D., 66, of Saco, Maine, died suddenly July 26, 1947, at his summer home at Biddeford Pool.

Doctor Hill was born in Biddeford, May 3, 1881, the son of Dr. Hampton E. and Myra Nutter Hill. He attended the Saco public schools, graduated from Thornton Academy in 1897, and from Bowdoin College in 1901. He attended Johns Hopkins University, and received his medical degree from George Washington University in 1906.

He started his practice in Biddeford with the late Dr. Willis Hurd in 1906. During World War I, he served as a Major in the Army Medical Corps attached to the British Army, and was stationed at the Princess Royal Auxiliary Hospital for Officers, Brighton, England, resuming his practice in Saco several years after the war.

He was a member of the York County Medical Society, the Maine Medical Association, and the American Medical Association. For many years he was Surgical Consultant at the Webber Hospital in Biddeford. He was an active member of the Masons, Rotary Club and the American Legion.

Doctor Hill and Doctor Laura Black Stickney purchased the Trull Hospital in Biddeford in 1923, and organized the institution which has continued in operation under their supervision.

He is survived by his widow, Mrs. Alice M. Lloyd Hill, and a son, Dr. Paul S. Hill, Jr.

American Congress on Obstetrics and Gynecology

The Third American Congress on Obstetrics and Gynecology, September 8-12, 1947, in St. Louis has scheduled three panel-type morning sessions on the following subjects:

(1) *Anesthesia and Analgesia,* Tuesday, September 9th.

(2) *Cancer,* Wednesday, September 10th.

(3) *Caesarian Section* on Thursday, September 11th.

The afternoon meetings of the Medical Section of the Congress will consider the Psychosomatic Aspects of Pregnancy on Tuesday; Pregnancy Complicated by Heart Disease, Diabetes and Tuberculosis on Wednesday; and Recent Advances in Endocrinology on Thursday.

Round table discussions will be held from 4 to 5 P. M. daily.

Further information may be secured from the office of the Congress, 24 West Ohio Street, Chicago 10, Illinois.

House of Delegates of the A. M. A. To Meet in Cleveland, Ohio, January 5 and 6, 1948

The Executive Committee of the Board of Trustees of the American Medical Association, meeting at headquarters July 25th, announced that the mid-winter meeting of the House of Delegates of the A. M. A. would be held in Cleveland, Ohio, January 5 and 6, 1948, followed by a general scientific session for the general practitioner on January 7 and 8.

Medical Films Available to County and State Medical Societies

Many very fine motion pictures were produced by the Bureau of Medicine and Surgery of the U. S. Navy during the last war, but the films are not easily available on a loan basis. Therefore, the A. M. A. Committee on Medical Motion Pictures is planning to include in the A. M. A. Film Library (535 North Dearborn Street, Chicago 10, Illinois), a select group of these basic films so that they will be readily available to county and state medical societies as well as to other medical groups. Medical films produced by the U. S. Army are available on a loan basis by writing to: Chief, Division of Training and Education, Office of the Surgeon General, War Department, Pentagon Building, Washington 25, D. C.

Change Time for Radio Program

A new time of presentation has been announced by the Bureau of Health Education for the A. M. A.—Mutual Broadcasting System weekly radio dramatization, "Stephen Graham, Family Doctor." This program, just extended to November 17th, will now be aired each Sunday afternoon at 2 o'clock, Eastern Standard Time.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

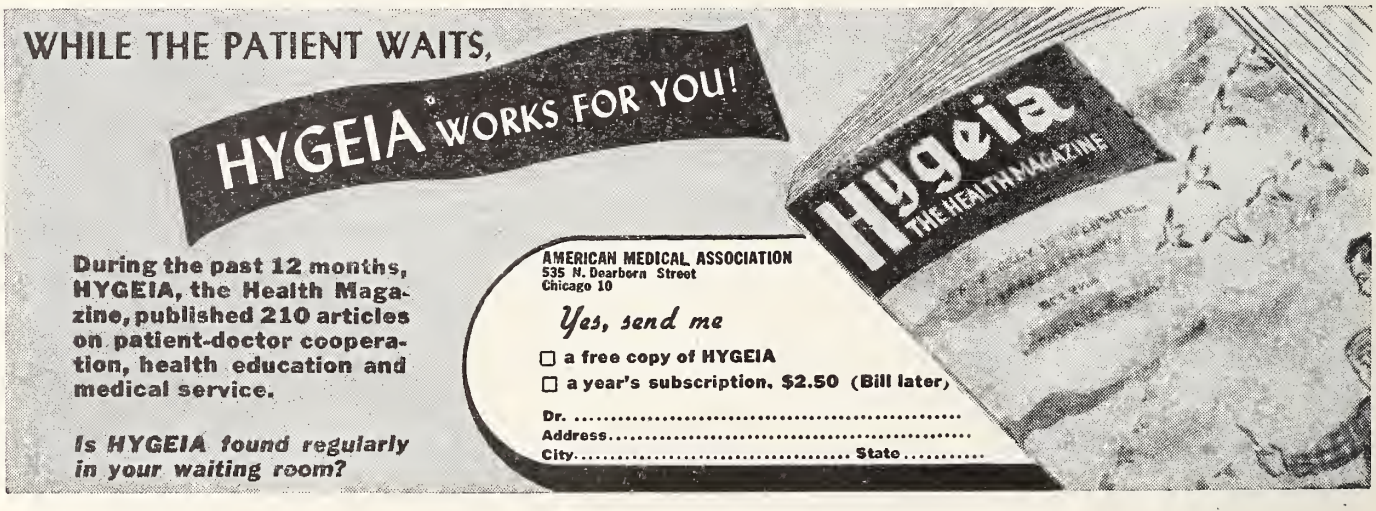
Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.



Book Reviews

"Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946"

Cloth. Price, postpaid, $1.00. Pp. 135. Chicago: American Medical Association, 1947.

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had not accepted certain of the preparations it had considered. The reports were mainly those of rejection; though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise of usefulness but not yet ready for adoption by the general and medical profession. In recent years, the tendency has been toward a preponderance of the educational type of report. In the present volume, both the condemnatory and the educational phases of the Council's work are represented.

There are three reports of vigorous condemnation: first, the report on Cabasil, a curiously unscientific mixture whose exploitation for use in a multitude of diseases is aptly summarized by the sub title of the report, "Quackery Unlimited"; second, the report on the pseudo-scientific Ethylene Disulphonate (Allergosil brand), a preparation of highly uncertain nature exploited to physicians for use in allergic conditions; third, Formula A-N-1, a joint report of the Council on Pharmacy and Chemistry and the Council on Industrial Health, concerning an expensive but poor substitute for aspirin and citrate of magnesia, cleverly promoted to industrial concerns for use in reducing absenteeism due to colds.

Among the status reports, the excellent article of Dr. Samuel M. Feinberfi, "Histamine and Antihistaminic Agents," is probably most worthy of mention. Since its appearance, the Council has accepted for inclusion in New and Nonofficial Remedies, the two new agents of this class evaluated in the article, Diphenhydramine Hydrochloride, and Tripelennamine Hydrochloride (Benadryl Hydrochloride and Pribenzamine Hydrochloride, respectively).

Pharmaceutical and scientific investigators, alike, will be interested in the informative report on the Council's new Therapeutic Trials Committee. Of special interest to manufacturers is a statement on the revised rules of the Council, though this exposition of the trends of Council policy is of concern to all who are interested in progressive rational therapeutics.

Attention is called to the several reports on the adoption of generic designations for drugs proposed or marketed under protected names. Not all such actions of the Council have been the subject of separate published reports; the recognized terms have appeared in the published descriptions of the drugs when accepted, and will be inserted in another Council publication, New and Nonofficial Remedies, as adoption of such designations for already accepted protected names proceeds.

"The Years After Fifty"

By: Wingate M. Johnson, M. D., Professor Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, with a foreword by Morris Fishbein, M. D., Editor of the Journal of the American Medical Association.

Published by Whittlesey House, McGraw-Hill Book Company, Inc., New York.

153 Pages. Price $2.00.

The pages that make up this book are not only fascinating but they contain much truth and comfort to those seeking knowledge to guide their lives. The various chapters deal with life, with love, and with death. The case they make for the existence of life after death is unusually strong. The belief is not forced on any skeptic, but the reader can decide. Its purpose is to keep intelligent man and woman prepared for the latter half of life.

"Advances in Pediatrics"

Vol. II

Editorial Board: S. Z. Levine, M. D., Cornell University Medical College, New York; Allen M. Butler, M. D., Harvard Medical School, Boston, Mass.; L. Emmett Holt, Jr., M. D., New York University College of Medicine, New York; A. Ashley Welch, M. D., University of Cincinnati College of Medicine, Cincinnati, Ohio.

409 Pages. Price $6.75.

Published by Interscience Publishers, Inc., 215 Fourth Avenue, New York 3, N. Y.

This volume presents selected subjects of contemporary interest and importance to pediatrists and practitioners alike.

The authors, who are recognized authorities in their field, provide in a comprehensive and scholarly manner new information charting future trends in pediatric research. The authors have brought this textbook well up to date. Each chapter is exceedingly well done.

Intracranial Aneurysms—Continued from page 190

for a period of about 30 minutes. If symptoms occur during these occlusive tests, ligation should be limited to the common carotid artery, at least as a first-stage procedure. In any case, it appears unwise to ligate the internal carotid in patients over 50 years of age. Proximal ligation reduces the systolic thrust within the internal carotid aneurysms with minimal hazard to the patient. If subarachnoid hemorrhage recurs in spite of this, intracranial clipping above the aneurysm may then be considered.

Aneurysms of the anterior cerebral and posterior cerebral arteries may be treated by double ligation or excision if they are located in an accessible position. Aneurysms of the middle cerebral, vertebral and basilar arteries still remain problems for the future.

Prognosis. The ultimate prognosis of ruptured intracranial aneurysms under conservative treatment is a mortality rate of about 50 per cent. However, this is a cumulative mortality figure and the rate for the first rupture is probably between 10 and 15 per cent. The second rupture may be expected to raise the mortality to about 30 per cent. Surgical treatment of the internal carotid aneurysms, as here outlined, has been uniformly effective in preventing subsequent aneurysmal rupture, in the writer's experience. There have been no demonstrable ill effects from the procedure in this series. It is urged that all patients who have a spontaneous subarachnoid hemorrhage should be studied in the manner here suggested and given the benefit of whatever surgical procedure is indicated.

Clinico-Pathological Exercise—Continued from page 195

preoperative diagnosis of mesenteric thrombosis. Operation was undertaken with the realization that if any extensive pathological process was found patient's condition was incompatable with a successful tensive section. On opening the abdomen in the left rectus a gangrenous loop of small bowel presented. Its appearance being quite characteristic of mesenteric thrombosis. Proximally and distally there was viable bowel visible. It was obviously impossible to eviscerate the man for complete abdominal exploration because of his condition, therefore, the presenting loop of gangrenous bowel was resected as expediciously as possible and a decompression enterostomy was done about the point of resection. At the conclusion of the resection the patient strained somewhat and several other loops of small bowel were extruded. These loops showed definite changes consistent with mesenteric thrombosis and extensive enough to be beyond the point of viability. Therefore at operation the diagnosis of extensive mesenteric thrombosis probably involving most of the small bowel was known prior to closure of the abdomen, however, closure was carried out because surgical therapy of sufficient extent to eliminate the disease would have been of a magnitude completely inconsistent with survival of the patient. To answer the question asked above — anti-coagulants were not considered because it was known post-operative that the patient's disease was sufficiently extensive at the time of operation to be imcompatable with survival. It might well be added, however, that in the instance of a sharply localized mesenteri thrombosis which is resectable anti-coagulant therapy is logical and should be used post-operatively as an available means of preventing extension of the thrombosis to areas beyond that already involved. Under such circumstances the use of Heparin and/or Dicumerol would certainly be of definite value.

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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, September, 1947 No. 9

*The Small Hospital and the National Hospital Program**

J. R. McGibony, Senior Surgeon, Assistant Chief, Division of Hospital Facilities, U. S. Public Health Service

With the full support of organized hospital, medical, and other interested groups, the 79th Congress inaugurated a new era of hospital history by the passage of the Hospital Survey and Construction Act on August 13, 1946. This legislation, originally called the Hill-Burton Bill, is now Public Law 725.

To review briefly the provisions of such a far-reaching and, in the hospital field, such a revolutionary move, it may be stated that the purpose of the Act is to provide Federal assistance to States to the end that "necessary physical facilities for furnishing adequate hospital, clinic and similar services to all the people" will be attained. The scope of the program reveals that it is, in spirit and in fact, not a Federal but a State program. In its final analysis, it is actually a community program. This is as it should be, for sickness is generally a community problem with causes that are community causes and measures of cure that are community measures. The success of the program depends upon the extent of responsibility assumed by communities and States.

The Hospital Survey and Construction Act authorizes an allotment of $3,000,000 to the States for inventory and survey of existing facilities and the development of a program designed to fill the needs. The allotment of these funds is based on population. Authority is given also for the appropriation of $75,000,000 annually for five years to assist in the construction and equipment of facilities. The allotment of construction funds is based on population and per capita income. However, all funds for both survey and construction must be matched with $2.00 locally for each Federal dollar. The Federal responsibility for administering the law rests with the Surgeon General of the Public Health Service who has the advice and help of the Federal Hospital Council. Any local project must be an approved part of the total State program to receive consideration by the Surgeon General.

Hospitals, public health centers and related facilities may be constructed under this program. By "hospitals" are meant general, tuberculosis, mental, chronic disease and other types, except those furnishing primarily domiciliary care. They must be non-profit organizations. A

* This paper was given at a meeting of the Maine Hospital Association at Poland Spring, June 9, 1947.

"public health center" is defined as a publicly owned facility for providing public health services, the scope of which is a matter of State law. "Related facilities" include laboratories, out-patient departments, nurses' homes, training facilities and clinics. "Construction" is defined as construction of new buildings, expansion, remodeling, alteration, initial equipment, and architects' fees. Off-site improvements and, except for health centers, acquisition of site are excluded. Priority must be given to rural and economically depressed areas. Certain requirements must be observed; these include non-discrimination.

Prior to July 1, 1948, the State must enact legislation requiring compliance with standards of maintenance and operation which are to be established by the State.

The need for some type of assistance in the improvement of hospital services has long been recognized. Modern diagnostic and therapeutic procedures reach an all too limited number of our citizens. The reasons for this are many and complex. One major factor is the lack of facilities and equipment. The best medical practice today requires a concentration of skilled personnel and equipment found only in good hospitals, medical centers or group clinics. A second major factor is shortage of trained personnel. With unequal distribution of professional people throughout the country, this shortage is acute in many communities.

The maldistribution of physicians is influenced by several factors: community purchasing power, adequacy of hospital facilities, degree of urbanization, proximity of medical schools, teaching facilities, and the presence of professional colleagues. Of these, the first three probably are the most important.

In 1938, counties with per capita income over $600 had eight times as many physicians as those with incomes under $100. Rural areas had only ⅓ the number of physicians in proportion to population as urban areas. These shortages certainly are not due to less need for medical care. We know that hospital facilities will attract physicians. In counties with incomes under $300 per capita, those with no hospitals had 60% fewer physicans than those with hospitals of 250 beds. Without proper planning in the placement of hospital facilities, it is obvious that this maldistribution will become more marked as time goes on.

Our national ratio of beds is approximately 3.4 per thousand population. It has been estimated that we need 170,000 new beds and 84,000 replacements in general hospitals; 209,000 new beds with 99,000 replacements for nervous and mental diseases; and 65,000 new beds and 17,000 replacements for proper care of tuberculosis patients. Approximately 2,400 new health centers of various types are needed. Beds for chronic diseases present a less tangible problem but here too this situation is serious.

Public Law 725 provides for Federal assistance not to exceed 4.5 general beds per thousand population; 5 beds per thousand for mental diseases; 2 beds per thousand for chronic diseases; and 2.5 beds for each annual death from tuberculosis. In addition, one health center to each 30,000 population may be provided in most States. In States with less than 12 persons per square mile, there may be one health center to each 20,000 population.

Public Law 725 also requires regulations for the planning and administration of the program. These regulations, which include minimum standards for construction and equipment, were developed with the coöperation of the Federal Hospital Council. In addition, they were reviewed in detail by committees of specialists from all professions. All concerned strived to place the minimum amount of red tape around the procedures for obtaining Federal assistance. Though there are some who feel that the standards are too exacting, the Public Health Service has no alternative, since its responsibility is to provide necessary legal protection for expenditure of Federal funds.

While the regulations apply equally to hospitals of all sizes, in formulating them it was realized that the small hospital presents problems which are exceedingly difficult to solve. A statement in Appendix A of the Regulations reads:

"These standards constitute minimum requirements for construction and equipment and shall apply to all projects for which Federal assistance is requested under the act. They are considered necessary to insure properly planned and well constructed hospitals and public health centers which can be maintained and efficiently operated to furnish adequate services.

"It should be particularly noted that the small hospital of 50 beds or under, presents a special problem. The size of the various departments will be generally smaller and will depend upon the requirements of the particular hospital. Some of the functions allotted separate spaces or rooms in these General Standards may be combined provided that the resulting plan will not compromise the best standards of medical and nursing practice."

This is particularly important to Maine since the Maine hospitals belong essentially to the small hospital group. I noted that of the 48 general hospitals in Maine, 32 have less than 50 beds, 9 have between 50-99 beds, 6 between 100-200 beds, and only three more than 200. The total of 2,921 beds gives an average size of about 60. There is every reason to believe that the present program will develop along these same lines and that the average institution will be less than 100 beds.

Maine has made commendable progress in the hospital field. Since 1933 Maine has had a licensing law for all private and public hospitals, exclusive of Federal and State institutions. There are six hospital councils in the State. Moreover Maine was the pioneer in establishing a coördinated hospital system. Such a system offers at least a partial solution to the problems of maintaining adequate standards in small hospitals, especially when hospital services are tied together both clinically and administratively.

To touch upon various optional facilities which local conditions may call for, one of the most important is the combining of public health services with hospital activities. This matter must be determined by local needs and policies. Nevertheless, it is believed that each of these activities can serve the community better by avoiding separate approaches in the application of preventive and curative measures. Generally, the average community hospital is called upon to provide outpatient services in order to discharge its full responsibility to the community. When this department and the public health department are joined with the offices for private physicians and dentists, the combination often makes for a desirable continuity of medical care by furnishing facilities for practitioners and the institution through a common source. At the same time, it maintains the physician-patient relationship without encroachment of the institution into the field of the practice of medicine.

Another optional facility is a school of nursing. The concensus seems to be that the small hospital with its limited facilities is not in a position to be used for an accredited nursing school, except perhaps through affiliation with a larger institution. But it might very well consider the training of employees as practical nurses or nurses' aides.

Once a community determines its need the first question is usually "how much will it cost?" This can only be determined locally since there is a wide variation in the cost of material and labor throughout the country. For the purpose of a rough estimate, let us consider that the small hospital requires 550 to 600 square feet of space per bed. Construction costs are usually found to range from $12 to $20 or more per square foot, giving total building prices of $9,000 to $15,000 per bed. Hospitals, by the way, are approximately 1/5 more expensive to construct than are ordinary buildings of the community.

The costs of operating hospitals of today have reached such proportion that the ability of the community to support a proper standard of service must be fully ascertained before planning for construction. In general, annual operating costs total about ⅓ the cost of the construction of the institution, or $2,000 to $4,000 per bed. Again, this figure can best be determined locally by studying the experiences of institutions within a given area.

An analysis of operating costs of 29 hospitals in Maine indicates that with a total of 2,119 beds, there was a gross expenditure of $4,575,700, or an average cost of $2,159 per bed. However, such figures are misleading without adaptation to the number of beds occupied. Since there is a direct relationship between the size of hospitals and the average daily occupancy, this is of particular importance in this State. The 32 hospitals with less than 50 beds had an average occupancy of 66%. Seven hospitals with 50-99 beds had an average occupancy of 75%; six hospitals with 100-200 beds averaged 70%; three hospitals over 200 beds averaged about 90%. Twenty-eight of these hospitals reported an average annual cost per occupied bed of $2,788. This latter figure might

Continued on page 224

*The Value and Use of the Clinical Record**

Dexter E. Elsemore, M. D., Dixfield, Maine, Rumford Community Hospital, Rumford, Maine

A clinical record should show sufficient cause in chronological sequence to justify the diagnosis and warrant the treatment and end results.[1] The value of a clinical record is directly proportional to its accuracy and completeness. It is of value to the patient, the physician, and the hospital. In my opinion the physician benefits most or loses most depending on whether the record is good or bad. He benefits from a good record by making a more accurate diagnosis. The chief illness of a patient may be modified by other conditions which are frequently not discovered unless the history and physical examination are complete. Every physician does occasionally fail to do as complete a history and physical examination as he should, and there are few who have not been embarrassed by it. A condition found by a consultant or a laboratory report ordered late may disclose a disease which should have been discovered and treated earlier. The physician may also be embarrassed to find at a late date that his memory has failed and the record does not show the location of injuries, the exact operative findings, or the dosage and mode of administration of a drug used in the treatment of a specific case. His embarrassment is more acute if these findings are disclosed in court, or should he be the defendant in a malpractice suit. Aside from these unpleasant situations the keeping of good hospital and office records actually makes the work of the physician easier. Much repetition is avoided at subsequent office visits or hospitals admissions if an accurate previous record is available.

The patient is benefited in a like manner. He pays for and deserves accurate diagnoses and proper treatment. He often pays more because his treatment is prolonged when the diagnosis is incorrect or incomplete. His interests are protected in court by a complete and accurate clinical record, especially in insurance cases. The patient is also benefited at later hospital admissions should be under the care of another doctor. His knowledge of his previous illness might well be meager or incorrect. He may even be saved unnecessary surgery.

Dr. Alton Oschner has said that "the character of the work done in an institution is directly proportionate to the completeness of its records. Complete and accurate medical records are invaluable to the hospital for the determination of the efficiency of its medical staff."[2]

This statement might apply better to larger institutions than most of us are associated with but even in the smallest hospital a careful audit of records will reveal inefficiency. Constructive criticism of the members or departments at fault will result in saving time and money and promote better service to the patient. The evaluation of various forms of therapy can be done only by study of results in a large number of cases. If a hospital is engaged in any form of clinical research, the records must be not only complete but some form of standardization must be carried out. Many systems of nomenclature are in use and perhaps most of them are adequate. A popular and very good system is The Standard Classified Nomenclature of Disease. This system

1. Establishes uniform standard of diagnostic terms.
2. Makes a clear distinction between the disease itself and its manifestations.
3. Permits every gradation of diagnosis.[3]

When properly installed a system such as this groups the records of all the cases with the same diagnosis together where they are immediately available. It also groups the most important features of each case. Records with diagnoses not comforming to the standard are practically worthless for statistical study.

The form of the record in any one institution should be the same for all cases in order to promote easy analysis. Printed form sheets have some advantages, particularly for some of the specialties, but they also have disadvantages in that there are apt to be important facts for which no space or heading has been provided.

* This paper was given at a meeting of the Maine Hospital Association at Poland Spring, June 9, 1947.

For the average surgical or medical case printed forms are not as adequate as a simple non-restricting sheet of paper. The record should of course follow a predetermined pattern; such as—chief complaint, present illness, past history, systemic inventory, family history, marital history, and physical examination followed by a tentative diagnosis. Operative notes, laboratory reports, X-ray and pathological reports, and progress notes should follow, after which a summary should be written and the final diagnosis made. Condition on discharge should be recorded as cured, improved, or unimproved as it applies to the complaint for which the patient entered the hospital. Photographs often show much more than words can describe. They should be taken and made a part of the hospital record in many cases.

To my mind the most important use of the clinical record is its current use while the patient is in the hospital. It is compiled and added to from day to day and is frequently reviewed, keeping fresh in the mind of the physician all the facts pertaining to the case and showing the observations of many people. The nurses' notes and the progress notes made by the interns and residents as well as those made by the physician in charge may contain information of great value. These notes should be made up of concise descriptive statements and actual quotations rather than general meaningless phrases such as "patient is doing well," or "condition unchanged since the last note." Too often the physician fails to write progress notes from day to day but waits until the patient is discharged. Much of value is omitted if this is done.

Another important use of the record is its use for presentation of cases at staff conferences. The primary purpose of the staff conference is to review and analyze the clinical work done in the hospital. This includes the study of all unusual cases and all deaths specifically with statistical analysis of groups of cases at intervals. The appendectomies, the hysterectomies, the cholecystectomies, the pneumonias, the cesarean sections, etc., should be studied for mortality, morbidity, reason for operation or mode of treatment and the end results. Unless the records are complete and easily accessible the study is not only of little value but is an extremely difficult undertaking. There is no better way to prove to a staff member the value of records than to assign him the task of reviewing certain phases of staff activities through the material in the record files.[4] At the staff conference all phases of the record should be frankly criticized as should the method of treatment and end results when such criticism is deserved.

The great increase in the number of patients covered by some type of insurance is resulting in an increased demand for copies of information contained in the hospital record. The number of records called into court for compensation and liability claims has also increased. This practice places the hospital in a difficult situation as the medical record must be treated as a confidential document. Information contained in it should be released when and to whom it properly belongs. The hospital should have specific rules to govern its policy in this respect. A review of this aspect of the situation was written by Adeline Kennedy, Medical Records Librarian at the Chicago University clinics, and published in *Hospital Management*. She recommends that:

"I. Information contained in the record should never be released in the court room until the record is sworn in court as evidence.

II. No information should be given voluntarily to any insurance company or any other third party, until the hospital authorities are fully satisfied that the patient, will a full understanding of the situation, requests that the information be given. This request should always be in writing.

III. Even with the patient's consent information of a privileged or confidential character should be given out only to the extent that such information is necessary and pertinent in determining the right of the patient against the insurance company.

IV. The action of the hospital should not be affected by the question whether the information is favorable or unfavorable to the rights of the patient or the insurance companies.

In giving out information according to these principles, clearly the hospital has the right to

determine the form in which the information shall be furnished.

We strike a universally responsive chord when we touch on the exasperating amount of non-hospital work that is done by physicians and librarians at the behest of insurance companies. Legitimate inquiries in the case where a hospital, doctor, welfare organization, veterans' bureau, or similar organization is working solely in the patient's interest are replied to in a spirit of professional pride and cooperation.

Non-legitimate inquiries are many and occur anytime from the admission of the patient to several years later, whenever the insurance company becomes acutely interested in looking up possible technicalities in a case. Most of the questionnaires contain at least thirty-five questions; most of them insidious, impertinent, distinctly not hospital business, or strictly privileged hospital business that should not be made public; and as a crowning piece of impertinence there is often a notary's form at the bottom of the sheet requesting the doctor to go before a notary for the signature and seal 'before this form will be accepted.' "[5]

She suggests:

"(1) Uniform action by all hospitals and associations requesting a signed permission of the patient before giving out information.

(2) Disregard of the fifty-seven varieties of insurance forms, and the use of a uniform hospital form, carrying only the points essential to the condition for which the patient entered the hospital for treatment."[6]

Certainly the adoption of such a standardized action in this respect would reduce the load on the record librarian and would avoid dispersing contradictory or confusing information.

I hesitate to open the subject of how best to obtain good clinical records. When I was assigned this subject, I happened to mention to one of my fellow staff members that I had to write a paper on the use and value of the clinical record. He immediately replied, "A better title would be the nuisance value of the clinical record." It is a problem for nearly everyone. With some staffs it probably is actually an impossibility. At the present time particularly, with a shortage of nurses, interns, residents and staff members, the quality of the records in many places has dropped. We must, however, continue to keep hammering away—keep up the pressure—keep the staff men record conscious. In time the shortage of help will be less acute and we hope the quality of the records will improve.

Footnotes

1. Kirkland, A. G: Approved courses for medical record librarians. *Bull. Am. Surg.*, 1941, 26:65, Jan.
2. Ochsner, A.: Medical records from viewpoint of surgeon. *Bull. Am. Coll. Surg.*, 1936, xxi, 38.
3. Logie, H. B.: Making and using diagnostic records —a new method. *Mod. Hosp.*, 1934, xlii, 49-54, April.
4. Spencer, J. H., Jr.: Medical records. *Bull. Am. Coll. Surg.*, 1940, 24:87-80, April.
5. and 6. Kennedy, A. C.: The medico-legal aspect of the medical record from the record librarian's viewpoint. *Hosp. Management*, 1936, 42:50-52, July.

Tuberculosis is a public health program which affects every single individual in the state. Every case of tuberculosis costs somebody in the community $10,000. Since 96 per cent of the patients cannot afford to pay their hospital expenses, that "somebody" is the taxpayer. This cost will go on and on until all the active cases of tuberculosis are located, hospitalized and prevented from spreading infection to others. *Health and Safety Medium,* Sept., 1946.

The campaign against tuberculosis should be regarded, not as an isolated or special endeavour, but as an important part of the general public health program. Though the control of other infectious diseases, better housing facilities and general living conditions will have their influence in lowering the incidence of tuberculosis, the chief factor will remain the deliberate prevention of tuberculous infection. G. C. Brink, M. D., *Can. Jour. Pub. Health,* Jan., 1946.

Clinico-Pathological Exercise

Case Presented at the Maine General Hospital, Portland, Maine

Edited by Joseph E. Porter, M. D., Portland

This is the case of a 21-year-old white male who was admitted to this hospital with the chief complaints of abdominal pain, nausea and vomiting of 60 hours duration. He was apparently well until 60 hours prior to admission, when he developed abdominal pain, fairly well localized in the right lower quadrant. This was shortly followed by nausea and vomiting. Forty-eight hours prior to admission the patient took castor oil and promptly vomited. Since that time, he had remained in bed and vomited everything he had taken. The nausea and vomiting and pain in the right lower quadrant persisted up to admission.

Past History: Prior to this illness, patient's general health had been quite good. At the age of 8 he was treated in this hospital for contusion of the scalp and was discharged two days later. At the age of 9 the patient was again readmitted to this hospital for acute bilateral otitis media. Bilateral myringectomy was performed, and the patient discharged four days after admission. Again at the age of 17 the patient was readmitted because of phimosis, for which a circumcision was performed, and the patient discharged five days after admission. No history of recent upper respiratory infections; no urinary difficulties. There had been no bowel movements since the onset of the pain sixty hours prior to admission.

Family History: Not contributory.

Physical Examination: On admission, revealed a well-developed, well-nourished, white male, appearing to be quite ill. Temperature 99.6°, pulse 88; respirations 20; B. P. 132/102. Head: Not remarkable. Eyes: Pupils equal, round, and regular; reacted to light and accommodation. Extra-ocular movements normal. Sclerae and conjunctivae clear. Ears, nose, and throat not remarkable. Mouth: Tongue moist. Neck supple; no adenopathy; no venous distension. Chest: Clear to percussion and auscultation; expansion equal and adequate. Heart: P. M. I. in 5th interspace, within the midclavicular line; normal sinus rhythm; heart sounds of good quality; A_2 greater than P_2; no thrills or murmurs. Abdomen: Soft; no real spasm; moderate tenderness to palpation in upper abdomen and on left side of lower abdomen. Tender mass the size of a tennis ball felt in the right lower quadrant; tenderness to palpation not as marked in the right lower quadrant as in the left lower quadrant. Bowel sounds normal. No costovertebral tenderness. Rectal examination: Slight tenderness on right side. Extremities and reflexes not remarkable.

Laboratory: Initial urine examination: Yellow; acid; no sugar; albumin 100 mg.; slight trace of acetone; loaded with WBC.; few RBC.; no casts. WBC. count was reported as 18,500, with 95% polys. On the second hospital day the WBC. count was reported as 20,200, with 84% polys, 15% lymphocytes, and 1% monocytes. The blood serology tests for syphilis were reported as negative.

The patient was given intravenous fluids, and thirteen hours after admission went to operation.

Discussion

Dr. E. P. McManamy: The salient features of this case may be summarized as follows: A healthy 21-year-old male who becomes ill 60 hours before admission. His past history and family history as recorded here may be disregarded, except for the fact that at the age of nine the patient suffered from otitis media, which may or may not have anything to do with the case. His symptoms are: (1) Abdominal pain, fairly well localized in the right lower quadrant. (2) Followed by nausea and vomiting. (3) The patient has had no bowel movements since the onset of his illness. The positive findings are: (1) Temperature 99°. Pulse 88. Blood pressure 132/102. (2) Patient apparently not dehydrated. (3) Abdomen soft; no real spasm; moderate tenderness in upper

abdomen and in both lower quadrants; more marked in the left. (4) A palpable tender mass the size of a tennis ball felt in the right lower quadrant.

The laboratory findings show a leucocytosis with an increase of polymorphonuclear cells above normal, and a urine with 100 mg. of albumin and loaded with white blood cells.

Let us enumerate the pathological conditions which come to mind as we reviewed the case. The first condition which comes to my mind is, of course, acute appendicitis with appendiceal abscess. Then a list of conditions such as: (1) Peri-nephritic abscess; (2) Tumors of the appendix and cecum; (3) Acute cholecystitis; (4) Diverticulitis of the colon or cecum; (5) Meckel's diverticulum; (6) Mesenteric lymphadenitis; (7) Perforated peptic ulcer; (8) Strangulated appendices epiploica; (9) Regional enteritis; (10) Strangulated inguinal or femoral hernia, with intestines or omentum or both in the herniation.

I. Peri-nephritic Abscess: The presence of pain in the right lower quadrant, a palpable mass, leucocytosis, albuminuria, and pyuria, can exist in a case of peri-nephritic abscess. But the illness being ushered in by gastro-intestinal complaints, the lack of a recent history of infection anywhere in the body, the absence of tenderness in the costo-vertebral region, and the loin, makes me doubt that this is the diagnosis.

II. Neoplasms of the Cecum and Appendix: Such pathological conditions as tumors of the cecum and the appendix are rarely, if ever, ushered in by such acute symptoms, unless a tumor should perforate, which is unusual without the tumor giving some previous warning of discomfort or change in bowel habit. Mucocele of the appendix is usually asymptomatic and is rarely palpated through the abdomen.

Acute Cholecystitis: An episode of acute cholecystitis might cause the above picture. However, infections of the gall bladder are rare in males of this age. There is no antecedent history of similar attacks, of qualitative dyspepsia of the flatulence type. The distribution of pain is unusual for cholecystitis—which usually causes pain in the right upper quadrant, with radiation through to the back, and there should be acute tenderness and spasm in the right upper abdomen. A gall bladder that could be palpated in the right lower quadrant should be acutely tender and the right iliac region should be more tender than the left. I feel we can safely rule out cholecystitis.

Diverticulitis of the Colon and Cecum: Simple acute diverticulitis may involve any portion of the large bowel, but occurs most commonly in the sigmoid and is frequently called left-sided appendicitis. Nausea, vomiting, fever, and leucocytosis may be present, especially if abscess formation occurs. Pain, tenderness, and muscle spasm are usually in the left iliac fossa. This condition is prevalent in the middle age group. There is usually a long previous history of chronic constipation, with recurrent attacks of pain in the left lower quadrant. The rupture of a diverticulum should result in a local peritonitis, and abscess formation near the diverticulum, and since this occurs most often in the left side, the left side is where the tennis ball should be.

There are two complications of diverticula formation which may be confused with acute appendicitis. The first concerns the presence of an acute diverticulitis in a loop of redundant sigmoid colon which has become adherent to the right lower quadrant. The other condition is solitary cecal diverticulitis. On 23 cases reviewed by Jonas, 36.8% of them occurred in patients under 40 years of age. Free perforation into the peritoneal cavity is rare, but slow perforation with abscess formation occurred in 18 cases. The abscesses are usually thick-walled and discrete.

Meckel's Diverticulum: This congenital outpouching of the ileum is a remnant of the omphalomesenteric duct, and has been found in about 2% of all bodies autopsied. It is located 30-90 cm. from the ileocecal junction. It is capable of inflammation and perforation and can cause acute symptoms similar to those mentioned in this case, and can be mistaken for an atypical acute appendicitis. The pain, tenderness, and palpable mass are most often localized in the midline, in the peri-umbilical region.

Mesenteric Lymphadenitis: This condition is frequently confused with acute appendicitis, and the diagnosis is made often at operation. It usually develops before adult life. Fifty to eighty per cent of cases give a history of repeated attacks of abdominal pain with nausea

and vomiting. We are all familiar with the confusing picture of an acute episode, and that there are no characteristics which set it aside from appendicitis, unless it be the temperature, which is more elevated than in some cases of appendicitis, and the presence of soreness near the midline and sometimes extending to the left side of the lower abdomen. It has been stated that there is a lymphocytosis present in these cases, but we all have seen cases where this is not present. Diarrhea is more commonly encountered than constipation. I have never palpated a mass in a case of mesenteric lymphadenitis. On this alone, I feel we can rule out the possibility of it in this case.

Perforated Peptic Ulcer: Everyone is familiar with the typical picture of a perforated peptic ulcer, with the agonizing epigastric pain, pallor, mild to moderate shock, nausea, and vomiting, characteristic board-like rigidity of the abdomen. Twenty-five per cent of cases will give no previous history of ulcer or stomach complaints. The average age of the patient is usually somewhere between 30 and 50 years. There should be shoulder tip pain in 50% of the cases. The onset of the pain is usually severe in the epigastrium, and may gradually shift to the right lower quadrant. The difference between pain in perforated ulcer and appendicitis when both begin in the epigastrium is that the pain of appendicitis is usually mild. In a typical case of perforation, there may be a period of symptomatic improvement after the initial onset of the disease. Constipation is common in this condition. The abdominal rigidity will be present in extent depending on the amount of gastric contents discharged. Occasionally, when the patient is first seen, there may be some tenderness in the right lower quadrant, due to the recent peritoneal irritation from the gravitation of gastric contents to the right iliac fossa. The abdomen is silent to auscultation, and rectal examination should reveal tenderness on the right side.

In the early hours of the disease, 12-24 hours, distension may be absent, fever and leucocytosis moderate. It is possible for an abscess to develop in the right lower quadrant in a perforation of a peptic ulcer. In this case, the history of onset is not good for ulcer perforation, and the patient's general condition at the time of admission is better than one would expect at the end of 60 hours.

Strangulated Epiploical Appendage: Epiploic appendages frequently undergo torsion, infarction, and calcification, and can produce symptoms and signs closely resembling other acute pathological lesions of the abdomen. Rarely is the correct diagnosis made preoperatively.

Pain, nausea, vomiting, and abdominal tenderness, and even a palpable mass may be present in some cases, with fever, and leucocytosis. The pain and tenderness is more often on the left side. In 1942, 178 cases presenting abnormal epiploic appendages were reviewed by a group of workers, and in 10 cases, diseased appendages produced symptoms necessitating operative intervention. Contrary to what is found with typical appendicitis, there is rarely a primary epigastric component with secondary extension and localization of pain. Nausea and vomiting is unusual. In this series studied, only 2 cases showed a leucocytosis above 10,000.

The typical picture following acute torsion is considered to consist of moderate localized pain and tenderness in the abdomen of a rather obese youth. In this particular case, the symptoms and signs are too well-marked, I feel, to entertain a diagnosis of a strangulated epiploic appendage, but it should be mentioned, however.

Regional Enteritis: In the earlier stages of regional enteritis, there may be signs and symptoms of pain, nausea, and vomiting, fever, leucocytosis, and localized tenderness in the right lower quadrant, and if perforation of the bowel occurs there may be a localized abscess in the mesentery or the peritoneal cavity, giving rise to a tender mass. The mass may be situated in the right iliac fossa, and have the size and shape of a thumb or sausage, and its margins are usually difficult to define.

A careful history usually will reveal that there has been a tendency towards diarrhea and possibly slight crampy pain for some weeks previous to onset of an acute episode. Also perhaps a past history of anorexia and weight loss.

Strangulation of a Hernia: The cardinal symptoms of a strangulated hernia with obstruction are abdominal pain, vomiting, and obstipation. Pain is rarely absent, and at the onset it is often cramp-like occurring in waves; later the pain may become constant. There is no description in this case of the type of vomitus, such as is characteristic of intestinal obstruc-

tion at various levels. The history of obstipation is characteristic of intestinal obstruction, but it is not necessarily a guiding symptom, since fecal contents distal to an intestinal block may be passed.

The presence or absence of distension is a point worth considering. Generally speaking, if intestinal obstruction were the cause of this patient's complaint, one would expect to find the presence of considerable distension. However, I recently operated on a patient who had an incarcerated hernia with obstruction and moderate strangulation of several days duration. This man was relatively free of distension.

The presence of a tennis ball mass in this case makes me think of a femoral or inguinal hernia which would contain bowel or omentum, or both. If one could see and feel this mass, to be able to localize it with its relation to other structures, it would be of benefit.

In the presence of dehydration, there may be leucocytosis. Also a moderate leucocytosis can exist with intestinal obstruction due to reaction within the bowel wall. If there was any dehydration in this case, it was not noted; and if obstruction did exist it must have been partial or incomplete.

I am at a loss to explain the urinary findings on the basis of a strangulated hernia, unless there co-existed a urinary tract infection or perhaps a nephritis which would account for the mild hypertension.

Intussusception: No differential diagnosis of an acute abdomen with a palpable mass is complete without including intussusception.

This condition is primarily one of childhood, especially the acute stages of it. Sixty-four per cent of patients with this condition are of the male sex, and it is acute in 85% of the cases. The classical picture of the acute onset of colicky abdominal pain coming in paroxysms, associated with nausea, vomiting, and the passing of blood and mucus, rings a familiar note, along with a palpable tumor which in the ileocecal type, is found in the right iliac region in the early stages. The diarrhea may give way later on to constipation. There may not be localized tenderness. The tumor may vary in size from walnut to egg size, and even tennis ball proportions. Chronic cases are more common in adults, the history usually being one of repeated bouts of colicky pain, with nausea and vomiting and diarrhea, also tenesmus and anorexia.

The past history in this case is negative for such complaints, and the whole story of the present attack lacks too many points in favor of intussusception.

Appendicitis with Abscess: Acute appendicitis with rupture and localized abscess fits nicely into the picture. The tenderness in the epigastrium and left lower quadrant might be due to 60 hours of straining and vomiting. The constipation is consistent with appendiceal abscess. The albuminuria, white blood cells and red blood cells in the urine, are consistent with abscess formation.

My first choice is regional enteritis, with abscess formation, possibly nephritis with mild hypertension. My second choice is appendicitis, with rupture and abscess formation.

Dr. McManamy's Diagnoses:

1. Regional enteritis, with abscess formation.
2. Appendicitis, with rupture and abscess formation.

Dr. James Parker: The description says that the abdomen was soft and that there was a mass in the right lower quadrant, tender to palpation. I think a more detailed description of this mass would be of help, and I would like to know whether it was fixed.

Dr. William MacVane: The mass was immovable.

Dr. Parker: I feel that a history of repeated vomiting, which he had had for 5 days, is somewhat against appendicitis with abscess formation. I think that the picture sounds more like intestinal obstruction. I do not believe that an abscess would result in complete obstipation for a period of 5 days.

Dr. Eugene O'Donnell: There is one thing that hasn't been ruled out, and probably doesn't apply particularly to this case, but I think it might be well to raise the question, and that is, ectopic right kidney. Such kidneys are normally prone to infection, and as I previously mentioned, while it probably does not apply in this case, it might be well to consider it. I feel the way Dr. Parker does, that a little more ade-

Continued on page 222

The President's Page

It might be of interest to know that the A. M. A. is conducting a National Survey of the medical needs of the country. Of course this will have to be done through the various county and local associations. At the Summer Council Meeting in August, your Executive Secretary was instructed to make a complete survey of the medical needs of the state, especially in the rural communities. He is to work with the County Associations in contacting the Granges, and other rural societies. It is planned to publish in the JOURNAL the communities in need of doctors. Every effort possible will be made to supply them with an M. D. If you know of such vacancies, please notify the Editor of the JOURNAL, so that your Executive Secretary can investigate. Remember, you are paying good money to him as our number one public relations man. His only desire is to produce for our good. If you have problems, or want a speaker, on Medical Economics, write into the Association, and ask to have Mr. Payson come and speak before your citizens' clubs. We have ahead of us a real job of educating the public.

The Fall Clinical Session will be held in Lewiston, the ninth and tenth of November, 1947. The House of Delegates will meet on the Sunday. This is the first time that the House of Delegates have met other than at the Annual Session. Your Council will try to get to your County Delegates the salient things to be brought up at the session, at least a month before the meeting. If you have a resolution to offer, anything for the good of the Society, or even an axe to grind, have your delegate prepare it in writing, and present it to the House, so that it can be acted upon expeditiously. Our Androscoggin confreres promise to put on a great show. Your appreciation can be best shown, by personal attendance and participation at the meeting.

STEPHEN A. COBB, M. D.,
President, Maine Medical Association.

Editorials

Maine Medical Association Council Votes to Hold Clinical Session at Lewiston—1948 and 1949 Annual Sessions at Poland Spring

The Council of the Maine Medical Association held its annual summer meeting in Sanford at the summer home of your President, Dr. Stephen A. Cobb, and were entertained in a typical Dr. Cobb manner; maybe best described as "royally".

This was a joint meeting of the Council and Scientific Committee, with all but two, one Councilor and one Scientific Committee member, present.

The ladies, too, were invited, and were graciously entertained by Mrs. Cobb.

A morning of relaxation including golf for the golfers, horseshoe pitching for the horseshoe pitchers, and talk fests for those so inclined, followed by a very delicious dinner, proved the ideal tonic to get the members of the Council and Scientific Committee in a business-like frame of mind—for the meeting was called to order at 2.30 P. M. with those present ready to discuss the matters on the Order of Business.

The 1948 Annual Session was first on the Agenda and, following a brief discussion, it was voted to hold the 1948 and 1949 annual meetings at the Poland Spring House, Poland Spring, Maine. Arrangements have already been made with the Poland Spring House for both of these meetings. The 1948 meeting will be held June 20, 21 and 22. It is, of course, early to make any definite plans for this meeting, but with Dr. Francis A. Winchenbach of Bath, Chairman of the Scientific Committee, in charge of the program, it might be well to tuck these dates away in the back of your minds. Dr. Winchenbach is teeming with ideas for a social as well as a scientific session—and will be glad to receive suggestions from anyone.

The Fall Clinical Session will be held in Lewiston, November 9th and 10th. A local committee is to be appointed by Dr. Michael J. Harkins, President of the Androscoggin County Medical Society, to work in conjunction with the Scientific Committee of the Maine Medical Association, and Dr. Carter, Secretary of the State Association. The members of the Androscoggin County Society are enthusiastic about this meeting and are planning a program you can't afford to miss—which will be published in the October issue of the Journal. A notice relative to the Clinical Session will be sent to each member of the Association in the near future—watch for it and plan to be in Lewiston for this meeting.

A supplemental meeting of the House of Delegates will be held the evening before the Fall Clinical Session. This is in accordance with a vote of the House of Delegates, at the annual meeting in June,

> that the House of Delegates, at the time of the Fall Clinical Session, be called into a supplemental session.

This will be the first mid-winter meeting of the House of Delegates, and it is believed that much can be accomplished by getting the delegates from the County Societies together at this time. A special notice will be sent to each County Delegate prior to this meeting in an effort to assure a 100% attendance.

The Journal of the Maine Medical Association was discussed in view of the fact that it has received some adverse criticism from several members. Dr. Carter, Editor of the Journal, called attention to several complimentary letters from other States, and to the numerous requests for copies of the Journal which are received regularly. One member stated that he had recently received copies of several Out of State Journals and had become quite proud of ours. Following considerable discussion as to what purpose the Journal is supposed to serve, and how best to make it of the most value to the members, it was

> VOTED that each Councilor appoint a man from his District as a member of the Editorial Board (of The Journal of the Maine Medical Association), to work in conjunction with the Editor to assist in building up the Journal and in securing material and papers for publication, and that each member of this Board

appoint one member from each County Society in his District to assist him in securing such material.

This seems a wise move and your Editor hopes that the members appointed to serve on this Editorial Board will receive active cooperation from the County Societies in this effort to make the Journal a magazine every member can be proud of—and will want to take "time out" to read.

The Executive Secretary, Mr. Payson, was authorized to make a survey of the State of Maine relative to rural medical care, and the need for doctors, through the Officers of the County Medical Societies, in conjunction with the Grange, Chambers of Commerce, and other lay organizations. Mr. Payson has written to the County Societies relative to this program, and it is hoped that they will give him every possible assistance.

The meeting adjourned at 4.35 P. M. following a vote that a meeting be held at the time of the Fall Clinical Session in Lewiston, to precede the supplementary meeting of the House of Delegates. The members of the Scientific Committee will be present at this time to report relative to the program for the June 1948 annual session—so if you have any suggestions send them to Dr. Winchenbach in the near future.

Average Length of Life Since 1847 Increased from 40 to 67

"In 1847 the average length of life of our people was about 40 years; in 1947, this has increased to almost 67 years. Such an accomplishment may be regarded as one of the major attainments of modern science," according to Edward L. Bortz, M. D., President of the American Medical Association.

Writing in the current issue of *Hygeia,* health magazine of the American Medical Association, Dr. Bortz points out that "medical science in the last 25 years has discovered remarkably effective weapons for the control of infectious diseases. Important new information with reference to nutrition, disorders of the glands, the control of diabetes and obesity, and our knowledge of various nervous and mental disorders have made the doctor a more effective public servant than in any previous time in the history of humanity.

"We are indeed a more healthy people today. We are living longer. The mature and productive years are increased in number, and the ravages of old age may be delayed if the public will cooperate with the medical profession in utilizing available information for the control of the diseases which are the common lot of all people."

Continuing, the article states in part:

"Probably no other group has a keener sense of social responsibility than has the medical profession. . . . More and more attention is given to the preventive aspects of disease. This includes an appreciation of nutritional requirements of the body, plus a number of other important necessities, such as rest, recreation and healthy mental outlook. These factors represent some of the principal interests of the modern doctor.

"Organized medicine has always been a strenuous exponent of the highest type of medical service for all people, regardless of financial status. The unsolved questions of an economic nature are being approached with the same sense of scientific objectivity, free from emotional heat, as science utilizes in its laboratories and clinics.

"To facilitate international exchange of health information, the control of disease, and medical research, a world medical association is now in process of formation. American doctors are deeply interested in this worthy project. Recently two distinguished members of the Board of Trustees of the American Medical Association flew to London to attend an organizational meeting with representatives of other lands.

"As international bonds are strengthened in the fields of science, medicine, the arts, and culture, a better understanding will be brought about for people of the various nations of the world. As leaders in the medical realm communicate with one another across national boundaries, they bring to their own people the

benefits of research and investigations in the fields of medical science which will improve the health of various populations. When folks understand each other and contribute to the welfare and happiness of members of the family of nations, the irritations and misunderstanding that cause so much unhappiness should be more susceptible of compromise.

"Doctors are vitally interested in the broader problems of national security and international stability. The American Medical Association is vigorously engaged in promoting the dissemination of information that will improve the health of the people of all nations.

"American medicine is blazing new trails; it is moving in forward directions to a day of better understanding and finer health for people near and far. The leaders of medicine in the United States, supported by a superb staff of highly qualified colleagues and experts in the various special fields of administration, health education, medical economics, legislation and research, are throwing all their energy into the search for more adequate control of the disorders that destroy health and shorten life.

"The American people can rest assured that the doctors of the nation will continue to find new methods for the control of disease, improved measures for the public health, and an enlarged scope for the enjoyment of human existence. To these high aims the American Medical Association dedicates its interests and support."

Proceedings—Ninety-third Annual Session House of Delegates

The Proceedings of the meetings of the House of Delegates held during the Ninety-third Annual Session, at York Harbor, Maine, June 22, 23, and 24, will be published, in part, in the Journal.

The first installment appears elsewhere in this issue and includes the report of the Council for 1946-1947 by the Chairman, Dr. Forrest B. Ames of Bangor, the Budget for 1947-1948 as recommended by the Council and approved by the House of Delegates, and the report of the Executive Secretary, Mr. Payson.

The balance of the procedings which includes reports of Committees and Delegates, Election of Councilors, discussions relative to the Maine Medical School, Prepaid Medical Care, the National Physicians' Committee, and miscellaneous matters will be published in future issues.

Clinico-Pathological Exercise—Continued from page 218

quate description of the mass, not only as to its size, but as to its site, would be useful.

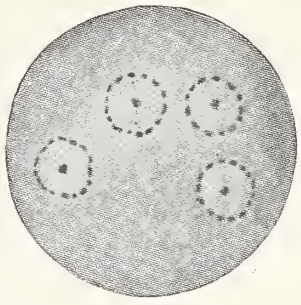
Dr. Isaac Webber: In my opinion, the physical findings and the history of this case could very well fit in with intussusception. I find nothing that would rule out this diagnosis.

Anatomical Diagnosis:

Intussusception of ileum, with gangrene.

Dr. Porter: The specimen received in the laboratory measured 30 cm. in length, and a large part of its center was gangrenous, dark reddish-purple in color, and covered with fine fibrin. The intestine consisted entirely of ileum, with a small amount of mesentery, and several microscopic sections taken from the vicinity of the intussusception failed to reveal the etiology of the process. This is somewhat unusual, in that most cases of intussusception in adults are due to some abnormality, as for example, a tumor or aberrent ectopic tissue in the bowel wall.

AMEBIASIS



"The symptoms of amebiasis are bizarre and simulate other diseases. The amebic etiology should not be overlooked, since it is impossible to foretell when amebic dysentery may develop." [1]

The nonirritating, orally administered, high iodine amebacide —Diodoquin (5,7-diiodo-8-hydroxyquinoline)—"is well tolerated. . . . The great advantage of this simple treatment is that in the vast majority, it destroys the cysts of *E. histolytica* and is, therefore, especially valuable in sterilizing 'cyst-carriers.' It can readily be taken by ambulant patients...." [2]

1. D'Antoni, J. S.: Amebiasis, Recent Concepts of Its Prevalence, Symptomatology, Diagnosis and Treatment, Internat. Clinics 1:100 (March) 1942.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice, Glasgow, M. J. 27:123 (May) 1946.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

The Small Hospital and the National Hospital Program—Continued from page 211

be taken as typical of present conditions in this State.

Personnel accounts for a large portion of the operating costs. The small hospital will usually need from 1 to 1.5 employees per patient, which brings the annual average payroll per occupied bed in Maine to $1,258. Supplies and equipment in the typical Maine hospital will average about $500 per bed with food constituting somewhat less than one-half of this amount. Equipment costs for hospitals of this size will be about $75 per bed. Laundry requirements for an average of 9 to 12 pounds of laundry per patient per day becomes a sizable item. Light, heat, maintenance and repair will require a minimum of $100 per bed, while miscellaneous items will probably total a similar amount. Thus it can be seen that to maintain an adequate standard of service, the $6-$10 per day for each patient is soon reached. The temptation often exists to curtail operating expenditures by reducing the most costly item, that of personnel, either in quantity or quality. As a rule, this is very poor economy. Good hospitals are expensive in dollars but poor hospitals are more expensive in terms of human life and welfare.

Thus you can see that there is a great challenge in the program that lies ahead of us. Not only must we provide hospitals where they are needed, but we must see that they are modern, well-equipped institutions. As leaders in the hospital field, you have a significant role in this program. Your State and your community looks to you for guidance in hospital planning. The Public Health Service also looks to you for the coöperation and understanding that will be necessary if this program is to fulfill the purpose which has been set for it—to provide the people of this country with the hospitals and health facilities necessary to a higher standard of national health.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine Eye and Ear Infirmary Maine General Mercy	1st Wednesday 2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

COUNTY SOCIETIES

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President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

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Secretary, C. W. Kinghorn, M. D., Kittery

News and Notices

Opening for General Practitioner in Maine

(York County)

West Buxton and Surrounding Towns

For information write to Mr. Parker Byron, West Buxton, Maine.

John C. Myer, M. D., has recently been discharged from Military Service, and resumed practice at North Berwick, Maine.

Henry P. Wagener, M. D., Guest Speaker at Portland Medical Club Meeting

Henry P. Wagener, M. D., Ophthalmologist at the Mayo Clinic, Rochester, Minnesota, was guest speaker at a meeting of the Portland Medical Club held Tuesday, September 2, 1947, at the Eastland Hotel, Portland, Maine.

Doctor Wagener, who has been participating in the Ophthalmological Study Council at Westbrook Junior College, spoke on "The Classification of Hypertensive Disease from the Retinal Standpoint as a Guide to its Management."

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., 192 State Street, Portland, Secretary.

List of successful candidates for medical licensure, July 1 and 2, 1947.

Through Examination

George Willet Burton, M. D., Milltown, N. B.

Manley Benjamin Cohen, M. D., 452 Beacon Street, Boston, Mass.

Graham Fraser Colquhoun, M. D., Victoria General Hospital, Halifax, N. S.

Frank Haines David, M. D., Augusta State Hospital, Augusta, Maine.

Robert H. Delafield, M. D., U. S. Naval Hospital, Brooklyn, N. Y.

Victor Grover, M. D., 384 Sterling Place, Brooklyn 17, N. Y.

Judah Lionel Guravich, M. D., 72 Pitt Street, St. John, N. B.

Hugh Hayford, Jr., M. D., Eastern Maine General Hospital, Bangor, Maine.

Charles Herrick Knickerbocker, M. D., Hartford Hospital, Hartford, Conn.

John Fessenden Miller, M. D., Camden, Maine.

Charles Francis O'Brien, M. D., Bangor State Hospital, Bangor, Maine.

Ralph Carleton Powell, M. D., Eastern Maine General Hospital, Bangor, Maine.

Abraham Oscar Stein, M. D., 47 Stevens Street, Woodmont, Conn.

Through Reciprocity

Ward Allen Albro, M. D., Dow Field, Bangor, Maine.

Edward E. Babcock, M. D., 23 Ohio Street, Bangor, Maine.

Jean L. Bolduc, M. D., 57 Water Street, Waterville, Maine.

Alcid F. Du Mais, M. D., P. O. Box 1096, Lewiston, Maine.

Clement S. Dwyer, M. D., 243 Main Street, Bar Harbor, Maine.

S. Frank Fox, M. D., 231 Walnut Street, Lawrence, Mass.

Paul C. Houston, M. D., P. O. Box 5, Plymouth, Maine.

Walter E. Penta, M. D., 316 Woodford Street, Portland, Maine.

Gardiner Pier, M. D., 111 East 94th Street, New York 21, N. Y.

George Joseph Robertson, M. D., 95 High Street, North Andover, Mass.

Philip B. Sullivan, M. D., 57 Abbott Street, Lawrence, Mass.

Henry Chas. Thacher, M. D., 987 Memorial Drive, Cambridge, Mass.

Rudolf Toch, M. D., 300 Main Street, Lewiston, Maine.

Arthur B. Wein, M. D., 17 College Avenue, Waterville, Maine.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

William H. Baker, M. D., 1878-1947

William H. Baker, M. D., 69, of West Buxton, Maine, died in a Portland hospital August 15, 1947.

Doctor Baker was born in West Paris, Maine, January 20, 1878, the son of William G. and Flora A. Young Baker. He attended Dover-Foxcroft Academy and was graduated from Bowdoin Medical School in 1901. He interned at the Maine Eye and Ear Infirmary and Marine Hospital in Portland, and practiced in Houlton and Danforth before locating in West Buxton in 1913.

Doctor Baker was a member of the York County Medical Society, the Maine Medical Association, and the American Medical Association. He was a member of the Standish Kiwanis Club, Buxton Lodge F. & A. M., and the Buxton Odd Fellow Lodge.

He is survived by his widow, Mrs. Arvilla B. Baker.

Howard Chapin Hanscom, M. D., 1875-1947

Howard C. Hanscom, M. D., 72, for nine years director of the Bureau of Institutional Service, State Department of Health and Welfare, died at his home in Boothbay Harbor, Maine, August 16, 1947.

Doctor Hanscom served as head of the institutional services from 1932, when he was appointed by former Governor William Tudor Gardiner, until 1941, when the office was abolished.

He was born at Auburn, Maine, June 12, 1875, and received his early education in Maine schools. He was graduated from Colby College in 1896 and from the College of Physicians and Surgeons, Columbia University, New York City, in 1900.

He is survived by his widow, Mrs. Mary E. Hanscom.

Proceedings

NINETY - THIRD ANNUAL SESSION

Maine Medical Association

YORK HARBOR, MAINE

June 22, 23, 24, 1947

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 22, 1947

The first meeting of the House of Delegates of the Maine Medical Association was held at the Marshall House, York Harbor, Maine, on Sunday, June 22, 1947, at three-thirty o'clock in the afternoon, with the President-Elect Stephen A. Cobb, M. D., of Sanford, presiding. (Frederick R. Carter, M. D., of Portland, read the Roll Call, and declared a quorum present).

CHAIRMAN COBB: The meeting will please come to order. In order to expedite anything important that comes up that really needs to be referred and thought about and reported at the second meeting of this House of Delegates tomorrow at five-thirty, I have appointed the following Reference Committee: Carl E. Richards of York County, Chairman; Clyde I. Swett of Aroostook County, Roland L. McKay of Kennebec County; Oscar R. Johnson of Cumberland County and Foster C. Small of Waldo County.

Also, at this time, I wish to appoint the Nominating Committee, consisting of Wilbur E. Leighton of Cumberland County; Merrill S. F. Greene of Androscoggin County; Francis A. Winchenbach of Lincoln-Sagadahoc County; Theodore E. Hardy of Kennebec County; John F. Hanson of Washington County and Martyn A. Vickers of Penobscot County; Dr. Vickers to be Chairman of the Committee.

The first thing on the agenda today is the report of the Council for 1946-1947 by the Chairman, Dr. Forrest B. Ames.

Dr. Forrest B. Ames, Bangor:

Gentlemen:

At a meeting of the Council of the Maine Medical Association held at Poland Springs on June 23, 1946, the following recommendations were voted to be presented to the House of Delegates for their consideration and action.

1. That the study of Prepaid Medical Care Plans be continued by a Committee to be appointed by the President. That this committee be authorized to take steps necessary to secure an Enabling Act which would empower the Maine Medical Association to adopt a representative insurance plan when such can be formulated.

2. That the House of Delegates of the Maine Medical Association go on record as in favor of the establishment of a Medical School in Maine as soon as feasible. That a committee be named by the President to carry on further plans.

3. That the House of Delegates of the Maine Medical Association express approval of the efforts of the National Physicians Committee in opposition to the passage of any Federal Legislation which would bring about government control of the practice of medicine.

4. That the employment of a full time Executive Secretary be authorized. This to be made possible by:

5. The approval of an increase in dues for the year 1947 to $25.00 per member.

6. That the emergency agreement between the Council representing the State Association, and the Associated Hospital Service, Inc. of Maine, be held in abeyance subject to new conferences between the Veterans Affairs Committee of the Maine Medical Association; proper Officials of the Veterans Administration, and the Associated Hospital Service of Maine. It is understood that any new agreement will give proper representation and authority to the Maine Medical Association.

7. That a budget totalling $17,671.87 be approved for the year 1946-1947.

These recommendations, after consideration by the Committee on Reference, were discussed in open meetings of the House of Delegates and approved by roll call vote with two exceptions:

1. No action was deemed necessary on the subject of employment of an Executive Secretary inasmuch as our by-laws authorize the Council to make such an appointment at its discretion.

2. That the annual dues be increased to a State total of $35.00 rather than $25.00. This was based on instructions to county delegates given prior to the June meeting that the dues be voted on a $35.00 basis.

The vote for increase in dues was by voice and was unanimous.

The foregoing seven articles presented an order of business and guide for activity of the new Council for 1946-1947. Printed reports of Committee Chairmen and Association officials give a detailed account of progress. However, it seems to be within my province as Council Chairman to give to you a brief report on each of these items and thus bring us up to this day of June 22, 1947.

1. Prepaid Medical Care Plan and Enabling Act. Through the careful efforts of a committee whose chairman was Dr. Eugene H. Drake of Portland, and aided by our new Executive Secretary, the State Legislature at Augusta was asked to pass a permissive enabling act. Permission was denied due to pressure of groups outside the medical profession as well as objections from within our own organization. Details of this will be presented to you in the report of the Executive Secretary.

2. The Establishment of a Medical School in Maine.

Much credit must be given to Dr. Edward L. Herlihy, chairman and his committee for informing the medical profession of Maine, the people at large, and organized groups throughout the State, relative to our need for a medical school. Also credit goes to our Executive Secretary, Mr. Payson, for his weeks spent with the Legislature in Augusta. As you know, the Senate overlooked an unfavorable committee report and voted in favor of the establishment of a Medical School. Lack of funds in our present set-up of taxes and revenue stopped further action on the bill. However, an interim committee for further study should keep this question alive and we shall hope for later and continued favorable action.

3. Approval of efforts of the National Physicians Committee.

This active group is still doing valiant work and it is a pleasure and privilege that tonight we shall hear of the present status of this vital question of Federal Medicine from one of the members of the National Physicians Committee.

4. and 5. Executive Secretary and increase in dues.

According to our by-laws your Council has authority to employ a full-time Executive Secretary. Without necessary funds that authority would be impotent. However, by over-riding a recommendation of last year's council that the dues be increased to $25.00 and making the total $35.00 necessary funds were made available.

A committee appointed by the President, Dr. John O. Piper, studied the appointment question and, after due consideration, offered the position as full time Executive Secretary to W. Mayo Payson, Corporation Counsel for the City of Portland. In addition to his legal background, Mr. Payson was a legislator with ten years experience in Augusta and a native with a well grounded State of Maine background.

Mr. Payson assumed office on November 1, 1946. Subsequent weeks were spent in Augusta through the Legislative session and in making get-acquainted contacts with the local County Societies. His own report of these few months indicate an efficient and thoughtful stewardship.

6. Veterans Affairs.

The committee with its Chairman Harold E. Pressey, M. D., of Bangor, held meetings as authorized and agreements were reached which were acceptable. A recent review of the State seems to indicate that the present method of handling medical care for veterans is, on the whole, functioning in a satisfactory manner and a recently revised fee schedule has been recommended for adoption. The liaison position of the Associated Hospital Service of Maine has been more clearly defined and it appears that this set-up must be maintained so long as we wish to retain the integrity of the Maine Medical Association as the one recognized medical group for Veteran's care in the State.

7. The Budget.

The report of the Treasurer details expenditures and receipts and shows a healthy balance, and justifies the wisdom of the delegates in fixing the new dues at $35.00.

In supervising or carrying out the mandates of the June 1946 House of Delegates this year's Council has held six meetings ending with one held this afternoon prior to this present meeting. These meetings were held:

One at Poland Spring; The Organization Meeting.

Three at Augusta.

One in Bangor at the time of the Fall Clinical Session Dec. 1 and 2, 1946.

One today at York Harbor.

Other matters considered during the year include:

1. Approval of a fund to establish Fellowships in Post-graduate study with a $5,000.00 fund available to supply loans of $500.00 to members of the State Association who have returned from service and need financial assistance in taking refresher courses which require from six to twelve months residence.

2. Approval of a Fall Clinical Session to be held in Bangor in December 1946.

3. Approval of a fee schedule for Medical Services to individuals helped by the Vocational Rehabilitation Division of the State Department of Education.

4. Many discussions were held relative to our relationship to groups practicing other forms of therapy under the present laws of the State. Our general attitude has been to develop the strength of our own organization and supply better medical care to the citizens of the State.

In considering the activities of the Maine Medical Association during the past year it would appear that we have embarked on a course which calls for continued effort along several basic lines of growth. Many of our projects are still in the developmental stage, but much valuable groundwork has been laid and continued unanimity of purpose and endeavor cannot fail of ultimate success.

Chairman Cobb: Thank you, Dr. Ames. Has anyone noticed any errors or omissions? If not, Dr. Ames' report will be filed, with your approval.

The next item of business is the presentation of the 1947-1948 budget, as recommended by the Council, and I shall call upon Dr. Ames for this presentation.

Dr. Ames: The Council has just met and has studied the expenditures of the past year, and wish to present to you the following budget for your consideration, and, if approved, for adoption for our business during the coming year.

I will itemize the gross details, and if anyone wishes any breakdown of figures, they are available, and we will be glad to furnish them.

Under the item of President's expenses, we recommend a budget of $300.00.

Salary of the Secretary-Treasurer and Editor, $3,000.

Assistant Secretary, $2,500.00.

Office Expenses for the general secretarial work, $1,000.00.

Medical Advisory Committee, which represents the work of Mr. Herbert Locke, who represents us on our medico-legal cases, $1,000.

Graduate Education, $100.00.

Special Committees, and for any item of special interest which may need to be studied, the members of which are appointed by the President, $100.00.

State Delegates and Council, $250.00.

Delegate to the American Medical Association, $250.00.

Council of the New England State Medical Societies; this is a membership fee which makes the State of Maine a member of this particular medical group, $100.00.

Traveling expenses for the Secretary-Treasurer, $100.00.

Clinical Session, which it is planned to have again this year, $250.00.

Total general expenses of $8,950.00.

Now, the office of the new Executive Secretary has been in operation, as I have already told you, since November of 1946. During that time, the Executive Secretary has received his salary, and there have been certain routine office expenses, a certain number of capital expenditures for equipment, etc., legislative expenses, membership in the different medical societies, conferences, meetings with the county societies, etc., in other words a total expense for seven months of $7,163.01.

In considering the budget for the coming year, the Council has received and voted favorably on the recommendation of the Executive Secretary that we add to our office equipment a mimeograph machine, which will enable him to send out detailed and frequent notices to the members relative to affairs of interest in the State and throughout the country in general, and it has been estimated by the Council that a figure of $12,000 should be set up to cover the administrative and executive work of the Executive Secretary for a twelve months' period, as of today. That is for a twelve months' period.

Therefore, for your consideration, we present a total budget of $20,950 in round figures, which has been rec-

ommended to you for your consideration, and, if you so wish, your approval.

CHAIRMAN COBB: Gentlemen, you have heard the reading of the Budget for 1947-1948. What is your pleasure?

DR. MARTYN A. VICKERS, Bangor: I move that it be accepted.

This motion was duly seconded.

DR. ALBERT W. PLUMMER, Lisbon Falls: Mr. Chairman, there is not a large percentage of delegates here. It strikes me that it should be laid on the table until tomorrow afternoon.

CHAIRMAN COBB: In other words, you would like to have it referred to the Reference Committee?

DR. PLUMMER: I move that the Budget be referred to the Reference Committee, and that it be tabled in this House of Delegates until tomorrow afternoon.

CHAIRMAN COBB: There is a motion before the House that the Budget be accepted as read. We had better vote on that.

DR. PLUMMER: I would make a motion merely that that motion be laid on the table until tomorrow.

CHAIRMAN COBB: You have heard Dr. Plummer's motion.

DR. VICKERS: I will not withdraw my motion. I move that the Budget be passed as read.

DR. JAMES M. PARKER, Portland: The motion before the House was seconded.

CHAIRMAN COBB: I wanted to be sure that we didn't rush anything through. The motion before the House is that the Budget be accepted as read, and this motion was duly seconded. We have a Reference Committee, of course, and if anybody wants the Budget to go to the Reference Committee, all right.

[The question was then called for.]

DR. KINGHORN: I will second the motion again and I shall not withdraw my second, either.

CHAIRMAN COBB: The question before the house is the acceptance of the Budget for 1947-1948 as read. All those in favor of the motion will please signify by saying "aye." Those opposed?

There was a chorus of "ayes" with two dissenting votes, and the motion was carried.

CHAIRMAN COBB: We will now listen to the report of your Executive Secretary, Mr. W. Mayo Payson, of Portland.

MR. W. MAYO PAYSON: I am not making a detailed report, because I have spoken to so many county societies that I have a feeling it will be re-hashing old material too many times.

I resigned as Corporation Counsel for the City of Portland on October 1st, 1946, effective on November 1st, that year, when I took over the work of your Executive Secretary. Perhaps it is incorrect to say that "I took over the work"; it might be better to say that I attempted to create a useful and worthwhile work for the Maine Medical Association.

Dr. Carter and I attempted to get either adjoining or combined offices in the Congress Building at 142 High Street in Portland. Dr. Carter's present office, as Secretary and Editor of the Journal, is so small that there was no possibility of being able to work together in that office. The building was so crowded at that time, and still is without any vacancies that will give us the modest combination of offices which we desire. This separation of offices, with one on the third floor and one on the fourth floor, has, of course, been some handicap to both of us, and particularly to me since Dr. Carter does not need assistance from me. I do, however, need a closer contact to that office to be in touch with all the material that comes through it, and more closely associated with all the business of that office. It is probable that we will be unable to obtain joint offices until some time this fall.

After taking office, I went to the House of Delegates meeting in Chicago in December. At the time that seemed a logical thing to do in order to get the feel of the business and to talk with some of the officials of the American Medical Association about the matters in which the Maine Medical Association was interested. I found the meeting of very little help because all of the officers with whom I wished to talk were so busy with the House of Delegates meeting that I was unable to get any time to sit down with them and talk about our problems here. I did, however, get some contacts with Executive Secretaries of other states and other public relations counsel which may develop usefully.

I attended also the February meeting in Chicago on rural health since that is specifically a serious problem here in Maine. That meeting was somewhat more profitable but there were so many different discussions going on at the same time that it was difficult to find which would be the more useful and I am afraid that my choices were usually wrong.

I have attended two Council meetings of your Association, and the midyear meeting in Bangor in December. At the Council meeting held at that time I was instructed to prepare and have introduced in the Legislature two bills, one for a medical school in conjunction with the University of Maine to be located at Bangor or Orono, and the other bill an enabling act to permit doctors of medicine to set up a voluntary prepaid medical care plan. As you all know, the voluntary prepaid medical care enabling act was killed. The medical school bill was rewritten to set up an interim committee for the study of the whole problem with an appropriation of $1,000 for expenses of that com-

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mittee. The committee did not seem to me to be so necessary for the purpose of getting at the facts as to whether a medical school was needed here and would be useful here, which Dr. Herlihy and his committee covered very thoroughly, but I felt that it would be politically useful to have a committee which, if it did report favorably, would be more broadly representative, and, therefore, have more public appeal than a committee composed solely of doctors. For that reason, this committee is to consist of three trustees of the University of Maine, three doctors selected by the Council, three laymen appointed by the Governor.

During the legislative session I was invited to attend a meeting in Hartford, Connecticut, by Dr. Miller who is the Chairman of the Committee of that State Society for a prepaid medical care plan. The Connecticut Society has abandoned its attempt to set up its own prepaid medical care plan and Dr. Miller wrote me in his invitation that they were at a point of discussion with representatives of insurance companies concerning terms and conditions of a policy to be issued by those companies. The then Insurance Commissioner of the State of Maine desired to go to this meeting so we attended together. The discussions had not reached a stage where anything concrete was brought out and ended by appointing committees from the two groups to explore the matter further. Dr. Miller has promised to advise me when anything further has developed. Rhode Island is discussing a similar proposition and their Executive Secretary has promised to keep me informed.

Since the Legislature adjourned I have visited and spoken to nine County Societies, explaining the legislative program and some of the reasons for the outcome of that program. The Societies were as follows:— Androscoggin, Kennebec, Penobscot, Piscataquis, Aroostook, Knox, Waldo, Lincoln-Sagadahoc. I visited the Cumberland Society but have not spoken to it. The other County Societies have not held meetings since the legislative session so far as I know.

I did not attend the convention in Atlantic City this month because I felt the expense would be considerable and the benefit to the Association meager. It might have been possible to obtain some small amount of favorable publicity for the profession in state papers if I had attended and obtained necessary information, but the wire services are, of course, quite adequate for that purpose. Furthermore, I believe that better public relations between the doctors and the public are not so much a matter of a few newspaper stories, as they are a matter of better interpretation of the two to each other. I speak with considerable hesitation on this phase because of my limited experience in this field; on the other hand, I have had several years' experience in public life myself and I am new enough to your organization to see these matters objectively in the light of that experience.

I feel that the two bills which your Association sponsored in this Legislature have to some extent already and will more in the future be very beneficial to the Maine Medical Association. I have this belief because both bills were unselfishly for the benefit of the public and not for any selfish advantage of the doctors. As time goes on legislators will understand this better than they do now.

Another example of what I believe is good public relations is the cooperation existing between the Veterans Administration and the Maine Medical Association in a medical service at home for the veterans. The people of the State of Maine have a very warm spot in their hearts, particularly for the veterans of this war, and the idea that those veterans may select their own doctor in their own home town is very appealing.

I know that some of you find the paper work bothersome in the extreme, and some of the rules onerous or impractical. But the public believes that the veteran under this system is receiving the best of care with the least dislocation to his own life, and any reluctance or refusal of doctors to cooperate would be difficult to explain and would have a definitely adverse public reaction.

The Railroad Retirement Act has been amended to give sick benefits to its covered employees. The reports which the doctor will be asked to make are short and simple and not numerous; in ordinary cases only one report, in some cases two. But the doctor has no assurance of being paid for his work since this is a sick benefit paid direct to the employee. On the other hand, if it were not for this sick benefit the employee would be getting no pay at all and he cannot get this benefit unless the doctor will make the report. If, after careful examination of this provision, it is not found violative of any tenet or standard by the American Medical Association it seems to me that cooperation of the individual doctors will tend to create good public relations.

At the request of the doctors of the Piscataquis County Society I am studying to see how doctors may reasonably be assured of their pay in automobile accident cases where there is insurance. Some of you doctors have no trouble in such cases now because your relationship with insurance companies is sufficiently friendly so that they now make sure you are protected. I have an engagement to meet with the Adjusters' Association at their next meeting in September. If I am permitted to go on with this proposition I shall tell them what the doctors' complaint is against the insurance companies and ask them to express just as frankly what the companies' gripe is about the doctors. If the problems can be ironed out then there should be a solution and cooperation beneficial to both groups. That is what I call good public relations.

I can assure you in all these matters I shall be very careful to suggest nothing until it has been carefully cleared as to ethics and principles with your proper authorities. Futhermore, I make no attempt to tell you how to run the business of your profession; it is, however, distinctly my job to point out from time to time ways in which the profession may obtain better relations with, and a more favorable attitude on the part of the public. If a half dozen of these projects can be worked out, I shall be much more pleased than I would be with fifty sugar-coated newspaper releases.

Chairman Cobb: You have heard the report of your Executive Secretary. Is there any discussion?

Dr. Clyde I. Swett, Island Falls: I move that the report of our Executive Secretary be accepted and placed on file.

This motion was duly seconded and was carried.

(To be continued in the October Issue)

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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, October, 1947 No. 10

*The Changing Concepts of Pre-Operative and Post-Operative Care**

James M. Parker, M. D., Maine General Hospital, Portland, Maine

It is a fact quite obvious to anyone that has followed the surgical literature during the last 10 to 15 years that less and less attention is focused on surgical techniques and more and more on fundamental problems relative to the patient's pre-operative evaluation and pre- and post-operative care. Many surgical procedures, namely thyroidectomy, gastrectomy and proctosigmoidectomy are essentially the same technically as in their early classical descriptions, but they carry a markedly decreased mortality and morbidity. The remark has often been made, with little distortion of fact, that a mediocre surgical technician with keen clinical judgement often delivers the finest surgical result. The changing concepts of pre- and post-operative care are continually placing in the hands of the surgeon knowledge that enables him to increase operability and decrease morbidity by applying proven therapeutic and prophylactic measures.

In the field of thyroid surgery the discovery of the biological effects of certain derivatives of urea in blocking the elaboration of thyroxin by the thyroid gland has resulted in the clinical use of thiouracil and 6-propyl-thiouracil. In the past surgery of thyro-toxicosis has required prolonged periods of hospitalization and preparation, surgery on patients whose metabolic state has introduced hazards that occasionally necessitated multiple stage procedures and a prolonged post-operative rehabilitation period. Utilizing thiouracil derivatives orally most cases can be prepared for surgery in an ambulatory state with remission of most of the cardinal symptoms, weight gain, and the return of the basal metabolism to normal pre-operative. These patients stand surgery without the hazards of severe metabolic upsets, are out of bed within 24 to 48 hours, and out of the hospital within a week. The side reactions of these drugs, the most important of which is agranulocytosis, are well known, and with careful clinical and laboratory follow-up during preparation can be spotted in their incipience. There is good reason to believe that they are rare in the use of propyl-thiouracil.

Unquestionably, the development offering the greatest relief to the over-taxed, under-staffed nursing personnel in our hospitals today is early

* This paper was given at a meeting of the Maine Hospital Association at Poland Spring, June 9, 1947.

ambulation. The practice is based on the sound physiological concept that man has organ systems adapted to upright posture and that prolonged bed rest leads to diminished efficiency of these systems as manifested by decreased vital capacity, slowed peripheral circulation with vasomotor instability, and decreased effectiveness of function of the bowel and bladder. It is supported by the embarrassing helplessness experienced by any of us after two weeks of bed rest. Early ambulation pre-supposes that in elective surgery the patient is maintained ambulatory pre-operatively. It consists of the patient rising with assistance and taking a few steps on the first or second post-operative day and increasingly thereafter. The contra-indications are unsatisfactory wound closure, shock, peritonitis and major cardiovascular conditions. Our experience with it has included this in gastric resection, gall bladder surgery, colon resections, vaginal-abdominal procedures, not to mention the common procedures of lesser magnitude. Indwelling Levine or Miller-Abbott tubes or cecostomy tubes have not interferred. Not only can the patient arise more easily during this early period than at the end of 10 to 14 days and find it less of a feat than getting on and off a bedpan, but after the first doubt is allayed by the accomplishment they pride themselves in it. There is a great consistency in the experience that the patient needs less opiates and fewer catheterizations, regains earlier normal intestinal tone, with early restoration of normal oral intake, and shows a lowered incidence of pulmonary complications. It appears not to be the whole answer to the phlebo-embolic disease problem. The implications from the nursing angle of the patient who is fully ambulatory in 4 to 5 days and home in 10 to 12 days instead of in 16 to 31 days is quite obvious.

Pulmonary embolism is an ever-present surgical hazard which has received much attention. While all agree to the importance of adequate fluid balance and supervised exercise of the extremities, those actively interested in the problem fall into two schools. The one advocating surgical ligation of the deep veins above the source of the thrombosis; the other the use of anti-coagulants as a means of prophylaxis and therapy. The rational in the first instance is by mechanically isolating the deep veins of the lower extremity to prevent the escape of an embolus from a bland thrombosis of these veins into the great veins and then into the pulmonary artery. In the second instance heparin and dicumarol are utilized to decrease the tendency to thrombosis, or in the presence of thrombosis to prevent propagating thrombi, which on breaking off become emboli. Either method applied with judgement offers a high degree of protection against fatal pulmonary embolism. Certain patients whose past history reveals a strong tendency toward thrombosis have in my experience been satisfactorily protected by giving dicumarol orally in a dosage controlled by a daily prothrombin time, beginning with the first post-operative day and continuing until they are fully ambulatory. Several others have come through major surgery without mishap after bilateral femoral vein interruption carried out because of the previous history of post-surgical pulmonary embolism. Post-operatively we have had an almost evenly divided experience with utilization of the two methods in the treatment of phlebo-embolic disease. The major emphasis in post-operative care must be placed first, on prophylaxis by avoiding dehydration and patient coöperation in the constant flexion extension exercises of the feet, second, constant vigilance to spot the earliest clinical signs of thrombosis or more common the most minor warning infarction, third, the emergency nature of therapy whether it be deep vein ligation or immediate heparinization continued until oral dicumarol has brought the prothrombin time within therapeutic range. In my personal experience no patient has died of pulmonary infarction where these measures were aggressively utilized.

Recent advances in the application of chemotherapy to surgical care are of paramount interest. The use of sulfa drugs parenterally in the treatment of peritonitis has increased with time as has the recognition of their occasional toxic effects on the hematopoietic systems and the kidneys. Penicillin, which is almost entirely free of serious side effects has, through reports from the Navy and laboratory experimentation, taken an important place in abdominal surgery. Its use in massage dosage of the order of 100,000 units every two hours provides an excess above that needed to inactivate the inhibitor elaborated by enteric organisms, providing an important therapeutic effect in

peritonitis. This was strikingly shown by George Crile, Jr., in a report on one hundred non-surgically treated cases of appendiceal peritonitis in the Navy Medical Bulletin in 1946. Also critical animal experiments reported in the 1946 College of Surgeons demonstrated its effectiveness in lowering the mortality of peritonitis of both appendiceal and small bowel obstruction origin. Clinical experience has borne this out and its use in massive dosage pre-operatively and post-operatively in peritonitis arising from appendicitis, strangulating obstructions, or other enteric origin is definitely indicated. Streptomycin in full dosage in conjunction with penicillin is sometimes of value when the latter alone proves inadequate. Its place in this field is as yet relatively small.

Surgeons have long sought a means of reducing large intestinal flora as a safeguard to resection and anastamosis. Sulfasuxadine and, most recently, streptomycin administered orally in either case for a period of three to five days pre-operatively and oft-times for several days post-operatively have proven of significant value in lowering the morbidity of large bowel surgery, increasing the safe indications for one stage resections and primary anastamosis for cancer of the colon. In our hands the use of the former has proved of considerable importance in bringing the period of hospitalization for these cases within the range of that for other less hazardous surgical proceedings.

The impact of war medicine on civilian progress of surgery is well shown in a revised concept of the use of blood and blood substitutes. Prior to our entry into World War II there was rapid development in the technique of handling and storing blood as a vital therapeutic commodity. The revolutionary accomplishments of war surgery were based on the massive use of this commodity,—replacement therapy in terms hitherto unimagined. Both through the lessons of war and the increased availability of blood, we, in civilian surgery, have learned to think of transfusion therapy in much more frequent terms than the occasional emergency. Patients who are to be subjected to extensive procedures are now routinely transfused until their blood is within essentially normal limits. The patient with a massively bleeding peptic ulcer is transfused repeatedly to restore blood volumes to normal as soon as possible and simultaneously apply the therapeutic test as to whether he is bleeding out as rapidly as he is transfused. Under such circumstances emergency gastric resection can be done to control hemorrhage with massive blood replacement in the operating room. It was not long ago that a pint of blood was thought to discharge the clinical responsibility. Now extensive surgery is planned with a generous backlog of ready, cross-matched blood, a plan which is carried to its logical conclusion—volume for volume replacement, and in cases of massive hemorrhage often a patient whose post-operative condition is better than pre-operative because of the fruits of the intelligent pre-operative planning. In the steadily falling mortality and the increasing operability rate of extensive gastro-intestinal surgery this is, in my opinion, the single largest factor of improved planning and care. Great credit is due to those of our confreres who have laboriously established and made it their responsibility to maintain blood banks, at times with too little coöperation from the surgeon in the problem of solvency in blood.

Nutrition, particularly in the terms of vitamins, has been a growing field of investigation for 20 years. The original impetus of Mann's studies of liver function as related to proteins and carbohydrates and fat metabolism was increased during the war years by the clinical and experimental realization of the vital part adequate nutrition plays in the repair of damaged tissues. Studies arising out of the Coconut Grove disaster have pointed out the massive protein and caloric requirement in the severely injured. Experience with paraplegic war casualties has shown that the rate of healing of large decubitus ulcers is readily accelerated by a high protein dietary. In civilian practice, I have seen the application of this fact result on several occasions in rapid healing of previously indolent lesions. The handwriting is on the wall that we must recognize the short-comings of the usual house diet with its 1500 calories and the inadequacy of 2 or 3 infusions a day of 5% dextrose in chronically depleted patients. Victims of long standing biliary tract diseases, peptic ulcer, or operable malignancy with an element of obstruction, frequently enter the hospital with a history and physical findings of

Continued on page 236

*Safeguarding the Patient: A Trustee Responsibility**

Raymond P. Sloan, New York City

In considering the subject of safeguarding the patient from the trustee's point of view I am going to start with a case history. Too frequently in such discussions as this we start with generalities and end precisely where we started. I am going to try to be completely realistic.

The superintendent of a certain hospital was obliged to discharge his medical record librarian under rather unpleasant circumstances. In recounting to the president of his board his problems in finding a suitable successor he was met with—"But is it actually necessary that we have a medical record librarian? Isn't that someone we might do without?"

Probably you are thinking that this incident is one I invented to prove the point of my talk, but I assure you that isn't so. I could name the president, the superintendent and the hospital. It isn't a small hospital either, for it now has some 350 beds.

I don't feel that we should necessarily blame that trustee for his ridiculous proposal. If he didn't know any better it was because no one had taken the effort first, to interpret to him his major obligation as a board member which is to assure proper medical standards to safeguard the patient, and second, the role that medical records play in maintaining proper professional standards.

We start with a lack of interpretation of hospital service to the lay group of which that trustee is a member. I hold that administrator more responsible than I do the trustee for the woeful lack of knowledge manifested. If he had taken steps to interpret hospital service to his president such a question never would have been raised. It is precisely for this reason that it has been suggested on numerous occasions that part of each board meeting be devoted to a presentation of the work of various departments by their heads, so that those men and women serving as trustees will know the "whys" and "wherefores" of hospital operation.

But let's go back a bit further. There is something even more basically wrong about the scheme that places in the important position of president of a voluntary hospital a man who knows so little about its operation that he should ask—"Is it actually necessary that we have a medical record librarian?" And this raises the question of whether trustees by and large recognize the responsibility they assume.

My personal feeling is that they do not. In making such appointments too much emphasis is placed upon the trustees' responsibility in maintaining the physical plant and too little upon their responsibility in maintaining the physical state of the patient. They think naturally in terms of their own businesses or professions in which balance sheets and budgets comprise the nomenclature. They deliberately fight shy of the product itself which is patient care because they know little if anything about it. In conducting their personal affairs it would become their business to learn about that product that they might plan intelligently for it. But the hospital is an extra-curricular activity. They lack the initiative to learn, and should they evince the willingness to do so who is to teach them?

Granted that the trustee has performed successfully his primary task of providing the hospital with a competent medical staff and an able administrator he must depend upon them for proper orientation and guidance. They must interpret to him their product which is patient care, and in such language that they will understand. Rather than frighten them with forbidding professional terms, however, it would be better to draw parallels to their own business organizations.

For example, getting back to the matter of records. Within the hospital as without, suitable records are vital in marking progress. We must maintain some measure of our success or failure. At regular intervals we have need to look back and review our accomplishments. As important as this is in any organization how much more important is it in dealing with life

* This paper was given at a meeting of the Maine Hospital Association at Poland Spring, June 10, 1947, by Raymond P. Sloan, Editor, *Modern Hospital,* New York.

and death. Any business man will admit too, that records are useless if they are not kept up-to-date. Furthermore, that one individual must be held responsible for the maintenance of those records.

The successful business man follows through on his product to satisfy himself as to "end results." The same should apply to medical service. Records should reveal what was wrong with the patient, what was done for him and with what results. If the results were bad where did the responsibilty lay—with the doctor, the disease, the hospital equipment or organization, or the patient? I maintain that the trustee has a definite obligation as guardian or trust officer of public health to insist that his hospital's records be complete and up-to-date.

Every business man will admit the value of audits in his own organization. Yet few hospital trustees recognize the importance of audits as applied to medical service. From the records that are maintained audits should be made regularly, and these should be made available for study. It isn't the quantity of the work done that counts; it is the quality of that work. Why not a progress or production sheet for the hospital as well as for the industrial plant.

No organization progresses today that is not engaged in some research—studies that will enable it to turn out a better "end" product. Advances in medical science may be attributed largely to the work that has gone on within our voluntary hospitals. We have need therefore, to check on our diagnoses through post-mortems, to check too, on those patients who have recovered, for there is much to be learned from them as well, and to hold necessary consultations and staff conferences.

Did you know? Frankly I did not, until I heard Dr. George Gray Ward, chief surgeon emeritus, Women's Hospital, New York, speak on the subject recently before the New York Academy of Medicine, that the Swedish government requires an annual report from every hospital in the land which is a real audit, showing not only the quantity of work done, but also the quality of the work and by whom. In other words, in Sweden the government demands an official accounting from all its hospitals of the manner in which they care for those in their charge, and this includes the individual record of the personnel. The reports demand the data that shows the exact dates of service and the quality of the work of each member of the staff.

According to Dr. Gray—"It is the responsibility of trustees to know the mortality and infection rates of their hospital, also the mortality and morbidity results and the percentage of successes, partial successes and failures of each member of the staff."

Now let's go a bit further in the matter of how the trustee may have interpreted for his benefit, his responsibility in safeguarding the patient. Every business man presumably knows the value of good public relations. Although for many years hospitals ignored this important phase in operating what is actually a public utility—that of health, today it is regarded as an essential. The difficulty is that we persist in looking for miracles, some bit of magic whereby overnight our enemies will be transformed into boosters. We have enlisted the services of the press; we have appealed to the loyalty of our volunteer and auxiliary groups; we have injected glamour into our annual reports. Some of us even have employed the services of professional "glad-handers" to go out into the highways and byways and make friends for us. I wonder if in striving so hard to find the answer outside of our hospitals we have overlooked the opportunities that lie within — the patient, who is our customer so to speak, also the personnel.

Proper treatment of those who are entrusted to our care—that is safeguarding the patient, would seem to me the surest, soundest and most logical path to good public relations. We frequently hear the slogan "The customer is always right." I wonder to what extent this policy is followed in many hospitals. As I stand alongside admitting desks or watch patients being discharged I become a bit skeptical.

Some hospital administrators have confided to me their troubles in getting their trustees to see the value of a public relations program. I don't believe there would be nearly so much difficulty if the parallel between satisfying the customer and safeguarding the patient were to be drawn. It is well to remember that no one can be a more successful salesman or saleswoman for the hospital than the patient who has been cured and who departs enthusiastic over the service he or she has received. It works forcefully, too, with the dissatisfied patient.

Your trustee who is successful in his own business or profession knows and takes personal interest in those who are responsible for maintaining the standards of that business. He meets with them, and is guided by their first-hand knowledge of the many details involved.

This fact might well be brought to the attention of those trustees who admit that they don't know who their doctors are, or the names of some, even. Such a situation is more common than you may think.

Not only is it the responsibility of the trustee if he is to safeguard the patient, to insure proper appointments to the staff, but to follow the progress of men on that staff. In addition to the opportunities of gauging the "end-product" afforded by the staff audit he should know the men personally. Formal conferences with the medical group, also annual or semi-annual social gatherings of the two are to be recommended. Just as the trustee will benefit from some interpretation of hospital service by his medical staff, so will the medical staff in turn benefit from interpretation of hospital policies. The two should form a team under the captaincy and jurisdiction of the administrator.

We have placed much stress in recent years upon the importance of selecting men as trustees of our voluntary hospitals who can contribute from their individual skills as lawyers, journalists, bankers, industrialists, engineers and such. All well and good, but in so doing have we not overlooked the most important factor of all which is that of safeguarding the patient. We should have learned by now that it is not wholly the modern efficiency or size of the physical plant that contributes the most to good patient care. It is the people who make up the team, their performance—their spirit.

I was extremely happy to hear Dr. Gray, who is a big-city surgeon say to his New York audience—"We all know that a small hospital situated in the country may give the highest type of scientific service to its patients."

In selecting hospital trustees of the future I would hope that we may place greater emphasis upon their obligation to establish and preserve high medical standards, making them recognize that the public more and more will demand such standards.

And, having appointed hospital trustees with the understanding that they have accepted a public trust, it is to be hoped that hospital operation may be interpreted to them simply and effectively in such terms that they cannot help but see certain parallels between it and their own organizations. And that in consequence they will study patient care and "end-results" with greater intelligence and understanding, always mindful of their individual responsibilities.

The Changing Concepts of Pre-Operative and Post-Operative Care—Continued from page 233

generalized dietary deficiency and serious protein depletion. No means other than oral intake will so readily restore them to a surgically acceptable state of nutrition. Even knowing that the diet kitchen with a little help in utilizing readily available protein concentrates can provide easily assimilable soft or liquid diet of 2,500 to 3,000 calories including 125 to 150 grams of protein, the tendency remains to order a routine diet supplemented by costly, but less effective, measures. Intravenous amino acids are of great value in the occasional problem, but their use is limited in the volume and duration of therapy and offers a poor substitute for the part played by a well balanced dietary with adequate vitamin coverage in the well rounded pre-operative and post-operative care.

Conclusion

This brief summary of certain trends in clinical care of the surgical patient has had as its purpose only to highlight and emphasize principles that personal experience have shown to be of cardinal value in the pre-operative and post-operative care of surgical patients in terms of a safer passage through channels still beset with occasional hazard. It is my feeling that it is constant reviewing of these changing values that offers the average general surgeon his greatest opportunity for progress toward better surgical results.

Clinico Pathological Exercise

Case Presented at the Maine General Hospital, Portland, Maine

Edited by Joseph E. Porter, M. D., Portland

This 17-year-old white female laundry worker was admitted to this hospital with the chief complaint of pain in the left lower leg. Approximately five years before admission she was struck on the left lower tibia by a stone; following which she had pain, and the overlying skin became dark. The pain and discoloration disappeared after a few days of local heat treatment. The patient had no further trouble until approximately 3 weeks before admission, when she again developed pain in the same region which lasted for one or two days. An X-ray at this time revealed a smooth defect in the middle third of the left tibia, apparently representing a bone cyst. Following the X-ray the pain recurred and the patient was referred to this hospital.

Past history: Four years before admission she was admitted to this hospital for a contusion of the right kidney, following a fall from a bicycle. A renal calculus is said to have been removed at this time. The patient had the usual childhood diseases; she denied rheumatic fever, scarlet fever, typhoid fever, tuberculosis, influenza, or any injury or operation other than as described above. Review of systems was essentially negative.

Family history: Father, age 43, living and well; mother, age 37, living and well; two siblings, living and well. No history of tuberculosis, rheumatic fever, typhoid fever, diphtheria, or cancer.

Physical examination: At this time was essentially negative, except for a small elevation in the middle third of the left lower leg, which measured 4 cm. in diameter, and approximately 0.5 cm. in height. The elevation was slightly tender, non-fluctuant, and slightly warmer than the adjacent skin. The leucocyte count at this time was 9,150, with 48% neutrophils, 46% lymphocytes, and 6% monocytes. The hemoglobin was 72%. The urine was negative. Cephalin flocculation test was negative. Serum alkaline phosphatase was 2.28 units. On the 9th hospital day curettage of the left tibia was performed.

Following discharge the patient was observed every 2 months, during which time X-rays revealed the defect to be getting smaller. Approximately one year after discharge, the defect began to increase in size, and the patient was readmitted to the hospital.

Physical examination at this time revealed the temperature to be 98.6°; pulse 68; B. P. 120/80. She was well-nourished and well-developed, and did not appear to be acutely ill. The head was not remarkable. The pupils were regular and equal, reacted to light and accommodation. Extra-ocular movements were normal. The teeth were in good repair; the tongue was moist and red. The neck was supple. No enlarged lymph nodes were palpated. The lungs were clear to auscultation and percussion. The heart was at the 5th interspace in MCL. There was a Grade II apical systolic murmur, without transmission. No diastolic murmur was heard. The breasts were normal. The abdomen was soft, non-tender; no masses were palpated. The liver, spleen, and kidneys were not felt. No herniae were demonstrated. There was a 4 cm. long healed incision over the anterior surface of the middle third of the left tibia; there appeared to be slight swelling of the lower end of the scar, with no discoloration or increased heat. It was non-tender. The patient was menstruating.

Admission blood count revealed hemoglobin 83%; WBC. 7,350; 58% polys; 2% eosinophils; 30% lymphocytes; 10% monocytes. Urine revealed a specific gravity of 1.020; 5 mg. of albumin; sediment was loaded with red blood cells; 1-2 WBC. were noted. The corrected sedimentation rate was 2 mm./hr. Kahn test was negative. X-ray at this time revealed a cyst in the middle third of the tibia, with no appreciable change from the films taken one year previously.

On the 11th hospital day the patient was taken to the operating room, where the cyst was curetted and filled with chips of cancellous bone removed from the ilium. Following operation the patient began to spike a temperature, up to 103° on the third day; she developed signs of

bronchopneumonia, which cleared rapidly following the administration of penicillin. She was discharged on the 33rd hospital day, 22 days postoperatively, on crutches.

Dr. William Casey: The first problem we are confronted with in this case is the relationship of her condition to trauma. Five years before admission she was hit over the shin with a stone, and suffered some soft tissue disturbance. I am not impressed by that trauma, and I do not think that it had anything to do with the present pathology. Four years before admission she had a contusion of her right kidney, and a renal stone was discovered and removed. At this time I should like to remark that in a young girl of 17 years, with a lesion of a long bone, and a history of renal calculus, we should think of von Recklinghausen's disease, and a calcium and phosphorus determination should have been done. Her age is right, and the involvement of the shaft of the long bone is also right. Calculus formation frequently precedes the discovery of involvement of the bone in von Recklinghausen's disease. The cephalin flocculation test has no significance to me in this case. We are obviously dealing with a benign condition. There is no indication of recurrent pain or systemic upset, and the lesion by X-ray was getting smaller. Then after two years the X-ray begins to show progression of the lesion, and it was therefore operated.

Dr. Jack Spencer: These X-rays (see Fig. I) were taken in April, 1946, and March, 1947. They show expansion of the tibia, thickening of the cortex, and decrease in bone density in the middle third of the tibia. The later films, taken with a Bucky, show more bone detail, and demonstrate thinning and expansion. In a young person of this age I would call this a benign cyst of the middle third of the tibia.

Dr. Casey's Summary: This is the case of a 17-year-old girl who had a solitary long bone lesion, without severe pain, and with no marked degree of progress over a period of two years. To me it is pretty obviously non-malignant, and I would entertain a Brodie's abscess, benign giant cell tumor, eosinophilic granuloma, and some form of localized osteitis fibrosa cystica. We can exclude the Brodie's abscess because it is in the mid-shaft of the bone. A fibroma can be excluded because it has much more pain. As far as I can determine, since only one bone is involved, I would exclude the osteitis fibrosa cystica, and my diagnosis would be a localized osteitis fibrosa cystica.

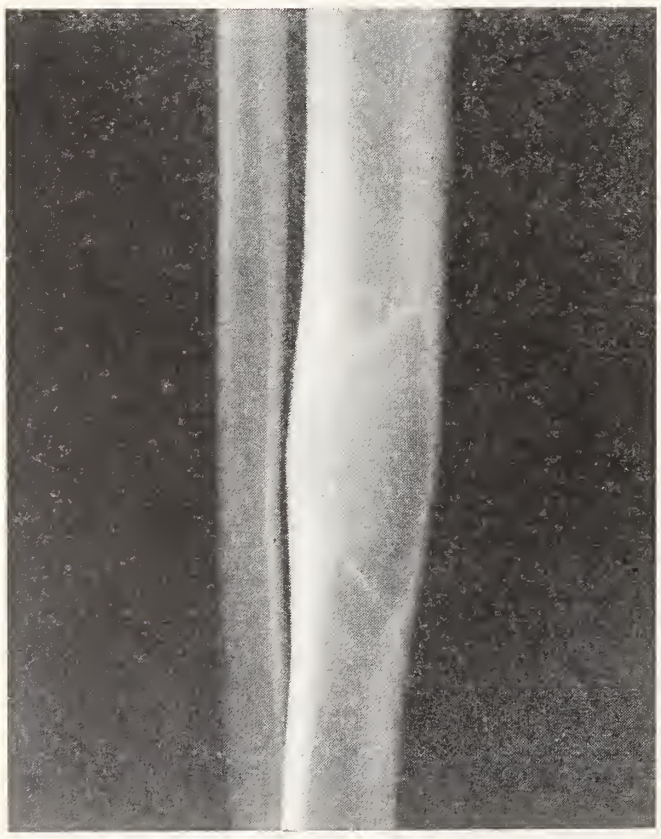


Figure I
First Roentgenogram taken prior to operation.

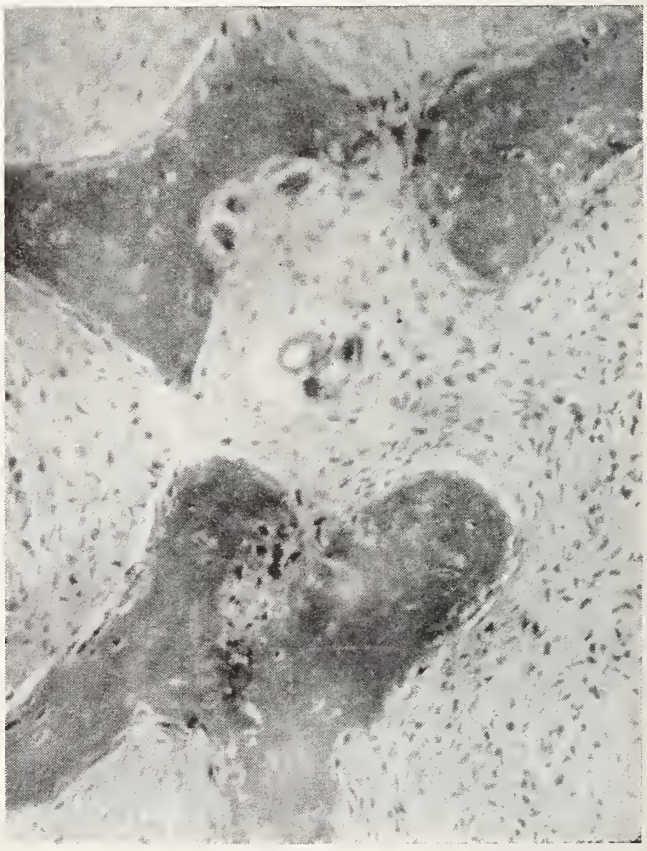


Figure II
Photomicrograph of tissue removed from cyst. Note replacement of marrow by fairly cellular fibrous tissue.

Dr. Casey's Diagnosis: Localized osteitis fibrosa cystica.

Anatomical Diagnosis: Fibrous dysplasia of bone.

Dr. Joseph Porter: Our diagnosis is also localized bone cyst, or in other words, fibrous dysplasia of bone, which is nothing more than a newer and better name for an older group of bone lesions, which had previously been called a solitary bone cyst. The condition has been recently renamed by Lichtenstein[1] and Jaffe[2] in papers appearing in 1938 and 1942. It is of interest that about one-third of the cases in their series showed some trauma, and in many instances ribs have been the seat of this lesion, and the fact of the ease with which ribs may be injured has been emphasized by the authors. Most of the cases reported by Lichtenstein and Jaffe were of the polyostotic variety of fibrous dysplasia, and since then there have been several cases, of which the one we have been discussing today is an example, of the monostotic type of fibrous dysplasia. The nature of this disease is still under discussion, and not settled; however, from a microscopical standpoint it more closely resembles a fibroma of bone than anything else(see Fig. II). It is of interest that recently McNairy and Montgomery[3] have been able to demonstrate nerve fibers in material which they studied.

References

1. Lichtenstein, L.: "Polyostotic Fibrous Dysplasia," *Archives of Surgery,* Vol. 36:874, 1938.
2. Jaffe, H. L., and Lichtenstein, L.: "Non-Osteogenic Fibroma of Bone," *American Journal of Pathology,* Vol. 18:205, 1942.
3. McNairy, J. D., and Montgomery, H.: "Cutaneous Tumors of von Recklinghausen's Disease (Neurofibromatosis)," *Archives of Dermatology and Syphilology,* Vol. 51:384, 1945.
4. Thannhauser, S. J.: "Neurofibromatosis (von Recklinghausen) and Osteitis Fibrosa Cystica Localisata et Disseminata, (von Recklinghausen)," *Medicine,* Vol. 23:105, 1944.
5. Schlumberger, Major Hans G.: "Fibrous Dysplasia of Single Bones, (Monostotic) Fibrous Dysplasia," *The Military Surgeon,* Vol. 99:504, 1946.

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General	1st Monday
	St. Mary's General	2nd Monday
Portland	Maine Eye and Ear Infirmary	1st Wednesday
	Maine General	2nd Friday
	Mercy	3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters	2nd Tuesday
	Thayer	Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.

The President's Page

There are Five Major Health Problems affecting this State, as well as many of the other States in the Nation.

1. Rural Health.
2. Public Health.
3. Medical Facilities.
4. Over all problems of Medical Economics.
5. Medical Education to the Public.

For this reason there is a nation-wide survey of Medical needs at this time.

The Maine Medical Association is interested to see that the people of Maine get the most adequate medical service that can be provided. In the last Legislature we sponsored two bills,—one for a voluntary prepaid medical care plan which we felt would have been of great usefulness to the lower-middle-income class group; the other was for a Medical School in Maine as a part of the University of Maine, to see if we couldn't educate doctors in Maine, and keep them here to practice.

We have in mind particularly that the rural areas of Maine frequently have no medical service at all and some of this is in Towns where a doctor could make a very good living. We do not, however, have sufficiently accurate information as to these places. We cannot, therefore, put forth intelligent effort to try to get doctors to go to these places.

The Council of the Maine Medical Association has authorized a thorough and exhaustive survey of the medical supply and the medical needs of every county in the State. We shall not be satisfied with a mere count of doctors and their locations. We propose after the count has been made that the officers of the county medical society sit down in conference with the officers of the Pomona Granges, the representatives of the Chambers of Commerce and other interested civic bodies and canvass thoroughly the medical needs of each county.

This is a beginning by the Maine Medical Association to search out the health needs in this State.

It would be surprising if this survey and these conferences did not uncover further health problems which the doctors together with the lay organizations can coöperate to solve.

Stephen A. Cobb, M. D.,
President, Maine Medical Association.

The above was presented by your President before the State Chamber of Commerce, Sept. 25, 1947, requesting their support.

Editorials

Fall Clinical Session
Lewiston, Maine, November 9th and 10th

The 1947 Fall Clinical Session of the Maine Medical Association, to be sponsored by the Androscoggin County Medical Society, will be held at Lewiston, November 9th and 10th.

The Clinical Session, to be preceded by a meeting of the Council and House of Delegates of the Maine Medical Association, will start off with a Social Hour at the Hotel DeWitt at 6.00 P. M., Sunday, to be followed by dinner at 7.00 P. M. Ashley Oughterson, M. D., Clinical Professor of Surgery at Yale University, is to be the guest speaker. Dr. Oughterson, who witnessed the Atomic Bombing of Japan, will speak on "Medical Aspects of the Atomic Bomb."

Monday's program consists of a continuous round of clinics—beginning at 8.30 A. M. at St. Mary's General Hospital and 9.00 A. M. at the Central Maine General Hospital, and continuing until 5.00 P. M. Luncheon will be served at both hospitals at 12.30 P. M. The program is published elsewhere in this issue of the JOURNAL, on colored pages so that you can't possibly miss it. Rather than go into any description of its excellence I leave it to each member to read and see for himself. In fact, it seems that the members of the Androscoggin Society have gone all out to make this a really worthwhile session to general practitioner and specialist alike.

And to top it off, Dwight E. Harkin, M. D., of the Boston City Hospital, is to be the guest speaker at the dinner Monday evening, which will be held at the Mansion House, Poland Spring, at 7.00 P. M. Dr. Harkin's subject will be "Cardio-Vascular Surgery."

Registration will take place Sunday night, November 9th, at the Hotel DeWitt, and Monday, November 10th, at the Central Maine General Hospital and St. Mary's General Hospital. Check these dates on your calendar today—and don't let anything interfere with your being among those marked present.

Maine Medical Association House of Delegates and Council to Meet in Lewiston, November 9th

The Council and House of Delegates of the Maine Medical Association will meet Sunday, November 9th, at the Central Maine General Hospital, Lewiston, preceding the Fall Clinical Session.

The Council which will meet at 2.00 P. M. will have as guests members of the Scientific Committee who are in charge of the program for the 1948 annual session.

The first supplementary meeting of the House of Delegates of the Maine Medical Association ever to be held will be called to order at 4.00 P. M. It is hoped that all delegates will be present and that they will come prepared to discuss the items on the Order of Business—which, except for last minute entries, will be sent them prior to the meeting.

If any member has any business which he feels should be presented to the Council or House of Delegates for action NOW is the time to send it to your Secretary, Dr. Carter.

Epileptic Patients Improved Most by Diet, Says Physician

Diet, not drugs, is the most important factor in the treatment of children who have epileptic convulsions, says Haddow M. Keith, M. D., Rochester, Minn., in the current issue of the *American Journal of Diseases of Children*, published by the American Medical Association.

A member of the Section on Pediatrics at the Mayo Clinic, Dr. Keith came to this conclusion after studying a large number of epileptic patients at the clinic who were treated with drugs, with a diet consisting chiefly of proteins and fats (no sugars or starches), and with both drugs and diet. A larger proportion of those in the last two groups either recovered or were improved.

Epilepsy is a disturbance in the rhythm of the brain from which one person out of every 200 in the United States is known to suffer. There is a recognizable epileptic rhythmic pattern, and in studying the brain through electroencephalography this pattern has been found in a great many individuals who show no signs at all of having convulsions. In some cases obvious damage to the brain is held responsible for the disease, but usually it seems to be caused by disturbances of body chemistry about which not very much is known. Epileptic attacks are most common in children, and may decrease, become less severe or disappear in later life even without treatment. These attacks take the form of grand mal, in which the sufferer loses consciousness, twitches and gets blue in the face; petit mal, in which the blacking-out of consciousness lasts for only a few seconds; psychomotor attacks, in which the sufferer seems to be conscious but doesn't remember afterwards what has happened; or Jacksonian seizures, characterized by an uncontrollable jerking limited to one side of the body.

In Dr. Keith's study two groups of patients were selected. The first group consisted of 300 consecutively admitted patients with epilepsy who were examined at the Mayo Clinic in 1940 or 1941 and for whom treatment was started at the time of the examination. One hundred eighty-seven of these patients reported from time to time until 1945. All of these had grand mal or petit mal or both, and all were treated either with diphenylhydantoin sodium and phenobarbital, alone or in combination, with the diet already mentioned or with a combination of the diet and the drugs. Where the diet was used it was maintained until the patient had been free of attacks for one year or more. It was then gradually changed to a normal diet, usually with a moderately limited amount of carbohydrate. When drugs were used in addition to the diet they were usually continued after the change in diet had been made.

Thirty-eight of the patients suffered from definite brain damage, and less than one-half of these were affected in any way by treatment. In those who improved the drugs seemed to have had more effect than the diet. Of the remaining 149 without obvious brain damage, however, approximately 27 per cent of those receiving the diet remained completely free of attacks for periods of from one to five years. Only about 12 per cent of those who received drugs but no diet remained well.

Dr. Keith's second group included all of the 311 patients started on treatment with the diet, alone or with drugs, at the clinic during the period from 1921 to 1930 inclusive. Their records were studied up to and including 1945. Of these, 190 patients had no obvious brain damage and gave the diet a fair trial. More than one-half of the 190 patients improved; 67, or 35 per cent, remained completely free from attacks for periods of from four to 22 years; and 33 remained well for 15 years or more. Patients with grand mal alone were most favorably influenced by the diet, those with petit mal alone were rather less favorably influenced and those with both grand and petit mal were the least definitely benefited.

There is apparently no marked correlation of tuberculosis with geographical position. Areas of high prevalence occur in the tropics, the temperate, and arctic zones. The same is true of areas of low prevalence. Climate appears to play a minor role, if any, in the prevalence of tuberculosis, and it is apparent that this disease has an extremely widespread occurrence throughout the world. Sarah E. Yelton, *Pub. Health Rep.*, Aug. 2, 1946.

Necrologies



Ralph W. Wakefield, M. D., 1877-1947

Ralph W. Wakefield, M. D., 69, past president of the Maine Medical Association and Hancock County Medical Society, died at his home in Bar Harbor, Maine, March 31, 1947.

Dr. Wakefield was born in Steuben, Maine, April 11, 1877, the son of George H. and Joan Godfrey Wakefield. He was graduated from Cherryfield Academy in 1898, Jefferson Medical College in 1902, interned at Jefferson Medical College Hospital, practiced in Philadelphia, Pennsylvania, two years, and in Bar Harbor, Maine, from 1905 to the time of his death.

Dr. Wakefield was President of the Maine Medical Association in 1937-1938, and had served on various Association committees and as Councilor for the Fifth District.

He was a member of the Hancock County Medical Society, the Maine Medical Association, the New England Surgical Society, and was a fellow of the American Medical Association and American College of Surgeons. He was President of the Bar Harbor Banking and Trust Company, and was on the staff of the Mount Desert Island Hospital.

He is survived by his widow, Mrs. Isabel C. Cleaves Wakefield.

William T. Elliott, M. D., 1870-1947

William T. Elliott, M. D., 76, died at his home in Berwick, Maine, February 26, 1947.

Dr. Elliott was born in Rumford, Maine, March 2, 1870, the son of Leonard D. and Eliza E. Elliott. He was graduated from North Bridgton Academy, from Dartmouth University, and received his medical degree from Dartmouth Medical School in 1900. He had completed forty-seven years in the practice of medicine, the first two in Bartlett, N. H., and forty-five in Berwick.

Dr. Elliott was a member of the York County Medical Society, the Maine Medical Association and the American Medical Association. He was a member of the Masonic Lodge and was on the courtesy staff of the Rochester (N. H.) Hospital.

He is survived by his widow.

COUNTY SOCIETIES

Androscoggin
President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

Cumberland
President, Edward A. Greco, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Maynard B. Colley, M. D., Wilton
Secretary, Kenneth A. LaTourette, M. D., Farmington

Hancock
President, Raymond E. Weymouth, M. D., Bar Harbor
Secretary, James H. Crowe, M. D., Ellsworth

Kennebec
President, Frank B. Bull, M. D., Gardiner
Secretary, Arch H. Morrell, M. D., Augusta

Knox
President, Wesley N. Wasgatt, M. D., Rockland
Secretary, Freeman F. Brown, Jr., M. D., Rockland

Lincoln-Sagadahoc
President, Stanley R. Lenfest, M. D., Waldoboro
Secretary, John F. Dougherty, M. D., Bath

Oxford
President, Walter G. Dixon, M. D., Norway
Secretary, Dexter E. Elsemore, M. D., Dixfield

Penobscot
President, Edward L. Herlihy, M. D., Bangor
Secretary, John E. Smith, M. D., Bangor

Piscataquis
President, George C. Howard, M. D., Guilford
Secretary, Norman H. Nickerson, M. D., Greenville

Somerset
President, Richard P. Laney, M. D., Skowhegan
Secretary, Maurice E. Lord, M. D., Skowhegan

Waldo
President, Seth H. Read, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, John F. Hanson, M. D., Machias
Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

Cumberland

A meeting of the Cumberland County Medical Society was called to order by Dr. N. S. Kupelian on September 26, 1947, at 8 P. M. During the business meeting a letter from Dr. Allan Woodcock, Chairman of the Advisory Committee of the Maine Medical Association, was read. He advises the society of the increasing number of malpractice suits in the State of Maine, and recommends that the society invite Mr. Herbert E. Locke, Association Counsel, to speak to the society and explain the ways in which these cases may be prevented.

Dr. Thomas A. Foster motioned that the Cumberland County Medical Society recommend as recipient for the A. M. A.'s Distinguished Service Medal for General Practitioners, the name of Dr. George H. Coombs of Waldoboro, Maine. This motion was seconded and unanimously approved.

Dr. Carl E. Richards, Councilor for the First District, announced that the Fall Clinical Session of the Maine Medical Association would be held in Lewiston on November 9th and 10th.

Dr. Barron F. McIntire of Yarmouth, Maine, and Dr. John T. Metcalf of Portland, Maine, were elected to membership.

Dr. Franz J. Ingelfinger, Associate Professor of Medicine at the Boston University School of Medicine, and Chief of the Department of Gastroenterology, gave an interesting paper entitled "The Diagnosis and Management of Lesions of the Small Bowel." Dr. Ingelfinger presented several X-ray pictures from actual cases, and illustrated his paper with excellent lantern slides. He discussed the use of the Miller-Abbot tube in the diagnosis and treatment of intestinal obstruction. The types of tubes, namely, the Miller-Abbot tube with two lumens, and the Harris tube with one lumen, were discussed with respect to their advantages and disadvantages. Clinical conditions were divided into three main groups and discussed separately by him. They are, namely, (1) Various causes of intestinal obstruction; (2) Regional ileitis, its diagnosis and treatment; and (3) Functional changes in the small intestine, with particular reference to the deficiency pattern, and their various causes. The paper was discussed by Drs. Isaac Webber, Langdon Thaxter, Jack Spencer, Donald Daniels, James Parker, and Eugene O'Donnell.

Dinner was served at the Maine General Hospital, preceding which there was a large attendance at the clinic presented by the staff of the Maine General Hospital.

JOSEPH E. PORTER, M. D.,
Secretary.

Hancock

A combined meeting of the Hancock and Washington County Societies was held at the Atlantic House, Milbridge, Maine, Wednesday, September 10, 1947, at 6.30 P. M.

W. Mayo Payson, of Portland, Executive Secretary of the Maine Medical Association, and Arch H. Morrell, M. D., of Augusta, State Pathologist, were present at the meeting. Dr. Morrell spoke about some of the problems in his work at the State Laboratory, and Mr. Payson outlined some plans of the Maine Medical Association.

Martyn A. Vickers, M. D., of Bangor, read a paper on "Allergy and Skin Diseases." After the presentation of the paper there was a general discussion period.

J. H. Crowe, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Blethen House, Dover-Foxcroft, Maine, September 18, 1947, at 7.00 P. M.

The following Officers were elected for the ensuing year:

President, George C. Howard, M. D., Guilford.

Vice President, John B. Curtis, M. D., Milo.

Secretary-Treasurer, Norman H. Nickerson, M. D., Greenville.

Delegate to the Maine Medical Association, Ralph C. Stuart, M. D., Guilford.

Alternate, Philip B. Thomas, M. D., Monson.

A good supper was enjoyed and a pleasant evening spent.

N. H. Nickerson, M. D.,
Secretary.

News and Notices

William Holt, M. D., of Portland, was re-elected President of the Maine Cancer Society, Inc., at a special meeting held in Augusta, October 8th.

M. Tieche Shelton, M. D., has resigned as Chief Medical Officer of the Veterans' Administration Center, Togus, Maine, and will resume private practice of medicine in Augusta in the near future.

The American College of Surgeons at the Thirty-third Convocation, held in New York, September 12, 1947, accepted into fellowship the following members of the Maine Medical Association:

Louis A. Asali, M. D., Portland
Carl E. Dunham, M. D., Portland
Merton N. Flanders, M. D., Waterville
William F. Mahaney, M. D., Saco
Alvin E. Ottum, M. D., Portland

Dr. Popplestone Named Superintendent of the Central Maine Sanatorium

The appointment of Charles B. Popplestone, M. D., formerly of the Pratt Diagnostic Hospital's resident staff and the Tufts Medical School teaching staff, Boston, as Superintendent of the Central Maine Sanatorium in Fairfield has been approved by Governor Horace A. Hildreth and his Executive Council.

Dr. Popplestone, who was located in Rockland, Maine, for several years, was graduated from Dalhousie University Medical School, Halifax, N. S., in 1924, and served his internship at the Toronto General Hospital. He was formerly an assistant physician for the Bangor State (insane) Hospital.

Dr. Popplestone, who was named by Institutional Service Commissioner Harrison C. Greenleaf, will assume his duties November 15th to fill a vacancy caused by the retirement of Dr. Charles D. Cromwell.

Col. C. Eugene Fogg, M. D., Retires from Maine National Guard as Brigadier General

Col. Charles Eugene Fogg, of Portland, has been retired from active duty as a member of the medical corps of the Maine National Guard with the rank of brigadier general, according to an announcement by Brig. Gen. George M. Carter, adjutant general of Maine.

Colonel Fogg, who was relieved from active duty December 27, 1946, when he reached retirement age, has served with three branches of the service in two wars.

State Medical School Group Nominated

Stephen A. Cobb, M. D., of Sanford, President of the Maine Medical Association, Clyde I. Swett, M. D., of Island Falls, and Edward L. Herlihy, M. D., of Bangor, will represent the Maine Medical Association on a nine member commission to study the need for a medical school in Maine, which was appointed September 9th at Augusta.

Named by Governor Horace A. Hildreth to represent the public were William F. Wyman of Augusta, Henry Wheelwright of Orono, and Phillips Payson of Portland.

Commission members appointed by University of Maine trustees to represent that institution, which has been suggested as a possible location for the school, are Agriculture Commissioner A. K. Gardner, State Education Commissioner Harland A. Ladd, and State Representative Edward E. Chase.

Creation of this commission was approved by the 93rd Legislature after the lawmakers rejected legislation for appropriation of funds to finance such a school in conjunction with the University of Maine.

Openings for General Practitioners in Maine

(York County)

West Buxton and Surrounding Towns.

For information write to Mr. Parker Byron, West Buxton, Maine.

(Aroostook County)

Easton: Population 1605, good schools, good roads and churches. A farming community.

For further information write to Mr. W. A. MacPherson, First Selectman.

Ophthalmological Study Council Discuss Medical Education in Maine

Talk about Medical Education in Maine, this month closed one of the stimulating and fruitful adventures in medical education here or anywhere, held right in our own frontyard.

One hundred and eight physicians are now well on their way in special training by means of The Basic Course of the Ophthalmological Study Council. The course ran at the Westbrook Junior College from mid-June to September 13th. The lecturers from ten states were leading educators staying a week or two at a time; the students were from twenty-six different states, seven were Canadians, one was from the Sandwich Islands. The long distance champion had been a medical missionary in Nigeria and arrived in a trailer equipped with wife, children and grandmother.

This is the same course that was given in Boston and again in St. Petersburg last year. The Council is being pressed to repeat it here next summer. No decision can be made until later in the month at the meeting of the Foundation for Vision of which it is a subsidiary.

A repetition seems likely after the outstanding success of this session. The accommodations and board furnished by the college were superior to either of the previous sessions and the cost less.

Locum Tenens Wanted. Locum Tenens wanted for town of 30,000 in Maine during April and May, 1948, on salary or percentage basis.

Address replies to: The Journal of the Maine Medical Association, 142 High Street (Rm. 323), Portland 3, Maine.

State Pediatric Clinic Schedule, 1947

Bangor — Eastern Maine General Hospital, 1.30 p. m.: Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 22, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Waterville — Thayer Hospital, 1.30 p. m.: Jan. 7, Mar. 4, Apr. 1, May 6, June 3, July 1, Aug. 5, Sept. 2, Oct. 7, Nov. 4, Dec. 2.

Presque Isle — Northern Maine Sanatorium, 1.30 p. m.: Mar. 26, May 21, July 23, Sept. 24, Nov. 19.

Clinic visits by appointment only. Referrals may be sent to: Division of Services for Crippled Children or Division of Maternal and Child Health, State Bureau of Health, Augusta, Maine.

Bureau of Health

State Services for Crippled Children Clinic Schedule, 1947

Portland—Children's Hospital, 9.00-11.00 a. m.: Jan. 13, Feb. 10, Mar. 10, Apr. 14, May 12, June 9, July 14, Aug. 11, Sept. 15, Oct. 13, Nov. 10, Dec. 8.

Lewiston—Central Maine General Hospital, 9.00-11.00 a. m.: Jan. 24, Feb. 28, Mar. 28, Apr. 25, May 23, June 27, July 25, Aug. 29, Sept. 26, Oct. 24, Nov. 21, Dec. 19.

Rumford — Community Hospital, 1.30-3.00 p. m.: Apr. 16, June 18, Aug. 20, Oct. 15, Dec. 17.

Waterville—Thayer Hospital, 1.30-3.00 p. m.: Feb. 27, Apr. 24, June 26, Aug. 28, Oct. 23, Dec. 18.

Rockland—Knox County Hospital, 1.30-3.00 p. m.: May 15, Aug. 14, Nov. 13.

Machias—Normal School, 1.30-3.00 p. m.: Apr. 9, July 16, Oct. 22.

Presque Isle — Northern Maine Sanatorium, 9.00-11.00 a. m.: Jan. 7, Mar. 5, May 6, July 9, Sept. 9, Nov. 5.

Houlton — Aroostook General Hospital, 9.00-11.00 a. m.: Mar. 4, July 8, Nov. 4.

Fort Kent — Normal School, 9.00-11.00 a. m.: Jan. 8, May 7, Sept. 10.

Bangor—Eastern Maine General Hospital, 1.30-3.00 p. m.: Mar. 27, May 22, July 24, Sept. 25, Nov. 20.

Portland — Cardiac, Maine General Hospital, 10.00-12.00 a. m.: Will be held every Friday with the exception of holidays (May 30, July 4, and Dec. 26).

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Joseph E. Porter, M. D.*

Waterville: *Sisters Hospital*
1st and 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd and 4th Thursdays, 10.00 A. M.
Director, *A. H. McQuillan, M. D.*

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Rockland, Rumford, Sanford, Waterville, Wilton, Millinocket, Old Town, Portland, Presque Isle, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Proceedings

NINETY - THIRD ANNUAL SESSION

Maine Medical Association

YORK HARBOR, MAINE

June 22, 23, 24, 1947

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 22, 1947

(Continued from the September issue, page 230)

CHAIRMAN COBB: Our next order of business constitutes the reports of committees that did not appear in the JOURNAL. Is Dr. Brown here to give the report of the Committee on Medical Education and Hospitals? [There was no response.] We will get that report later.

Is Dr. Gottlieb here to give us the report of the Cancer Committee? [There was no response.]

Is Dr. Johnson here, to give us the report of the Social Hygiene Committee?

DR. OSCAR R. JOHNSON, Portland: Mr. President and members of the House of Delegates: A week ago, I received a letter from Dr. Carter, our Secretary, requesting the report from the Social Hygiene Committee.

(Dr. Johnson presented his report relative to the Venereal Disease Law now in effect in Maine, which with ensuing discussion is on file in the Maine Medical Association office in Portland, and the following motion was accepted.)

DR. CHARLES W. KINGHORN, Kittery: I move that the Council, together with Dr. Johnson, Chairman of the Social Hygiene Committee, be empowered to draw up some regulation to take care of this matter of reporting venereal disease patients who go to the clinics.

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THE CHAIRMAN: All those who are in favor of Dr. Kinghorn's motion will please signify by saying "aye."

There was a chorus of "ayes" and the motion was carried.

THE CHAIRMAN: Dr. Leighton has gone to Europe for two months, and therefore we do not have his report on the Investigation of Collection Agencies.

Is the Chairman of the Committee on Industrial Health here? [There was no response.]

Is the Committee on Conservation of Vision ready to report. We have a letter from Dr. Howard F. Hill of Waterville, Chairman of this committee, which I shall ask Dr. Carter to read.

[Secretary Carter then read the following letter from Dr. Hill.]

June 16, 1947.

Dear Doctor Carter:

A meeting of the Conservation of Vision Committee will be held on Tuesday, June 24, at 12.30 noon. This will be held in order to meet with the State Health and Welfare Department, principally to determine the best type of aid we can give the Department. We are also going to take up the question of what is to be done about cross-eyed children who are wards of the State.

As I will not be able to be at the meeting of the House of Delegates Sunday, I am sending this as a preliminary report. The results of the meeting will be sent to you later.

DR. KERSHNER: I move that the report of Dr. Hill be accepted and placed on file.

This motion was duly seconded and was carried.

CHAIRMAN COBB: The next report is that of the Amy W. Pinkham Fund Committee, and I shall call upon Dr. Foster for that report.

DR. THOMAS A. FOSTER, Portland: Mr. President-Elect, the Amy W. Pinkham Fund is intact, and the Committee has a proposal to come before them at this session. I request an opportunity to bring in the full report at the next meeting of the House of Delegates.

CHAIRMAN COBB: Dr. Foster will report at the meeting at 5.30 tomorrow.

We shall now listen to the report of the Delegate to the American Medical Association meeting, Dr. Foster.

DR. FOSTER: Mr. President-Elect, and members of the House of Delegates. First, I should like to speak unofficially about the House of Delegates and express my thanks to this House of Delegates for electing me to represent you at the American Medical Association, which is, indeed, a great honor. I assure you that it is very much appreciated.

[Dr. Foster's further remarks were outside the record, after which he read his formal report.]

The 100th Anniversary of the American Medical Association, the Centennial Celebration, was held in Atlantic City, New Jersey, June 9th through to the 13th. Members of the Association who had the privilege of attending declare it the most brilliant, most successful annual convention ever sponsored by the association. One individual just couldn't report adequately on the exhibitions and achievements of the meeting.

As your delegate I would like to report to you on the state of the association, the deliberations of the House, some recommendations of your officers, and some resolutions approved by the delegates.

The association is in a strong position. The membership roster contained on April 1st, 1947 — 132,224 members, the largest ever recorded. Maine had 780 members, but only 358 Fellows.

The Treasurer reported a total of invested and uninvested funds as of December 31, 1946, $4,744,085.04, and an American Medical Association Research Fund on the same date of $1,500,000.00.

NOTES ON THE DELIBERATIONS OF HOUSE

The first business of the meeting was to elect the recipient for the Distinguished Service Award. It is pleasant to report that Dr. Henry A. Christian was selected.

Next Dr. Harrison Shoulders, President, made his address. Dr. Shoulders spoke with earnestness and conviction and devoted a major part of his address to methods for educating medical students to become general practitioners. He recommends the creation of

a committee to study the subject and to set forth procedures whereby General Practitioners could have places on Hospital Staffs and beds for their patients.

Dr. Edward H. Bortz of Philadelphia, who was installed as President to succeed Olin West who had resigned because of ill-health, gave a serious address which is the leading article in the JOURNAL of June 14. I recommend the address for all to read. Here one will find the answers to some of the questions about the American Medical Association. It would be an impudence to debate here on any single part of this splendid address. Please read it and become more fully acquainted with the objectives of the American Medical Association, your great and good medical association.

There followed after these annual addresses six long sessions of the House.

Many distinguished guests were introduced from Iceland to China and Egypt. The British Medical Association was there in force, and brought as a gift a gavel and stand fashioned from the Mulberry Tree which stood in the yard of the house where Charles Dickens lived and wrote his familiar novels. The British Medical Association have bought the house and erected a building which necessitated cutting down the Mulberry Tree. The Chinese delegate brought a handsome scroll with a Pine Tree which in China symbolizes long life. From Switzerland came a beautiful scroll, also, and many other gifts were presented as testimonials to the achievements and the generous help received from the wisest and greatest of all medical associations in the world. One could not help but feel that the delegates from foreign countries were sincere in their expressions of appreciation. They gave the impression that they favored the American way of life, and wanted none of the dictatorial or Communistic way of life.

After greeting warmly the distinguished guests, the House settled down to regular routine, and the new business to come before the delegates was introduced. New resolutions were varied and many. The ones dealing with major issues I will present. First let me say that Raymond Rich, the New Public Relations Counsel, resigned and the resignation was promptly accepted by the Trustees without regrets. It had become apparent that he was not the right man for the job, and the delegates authorized the trustees to start negotiations with some reliable public relations concern.

A resolution to re-affirm confidence in the National Physicians' Committee was approved after a friendly discussion.

Another to approve courses for practical nurses in approved hospitals was adopted. Others were approved as follows:

To create a standing Committee or Council to continue the work of the National Emergency Medical Service Committee, a special Committee appointed in 1945.

This Committee, of which Dr. Bortz was Chairman, recommended the establishment of the Council or Standing Committee.

It was felt that in times of peace the doctors of the Country through their official organization, the American Medical Association, should make plans for procuring and allotting medical and allied personnel in case of a national emergency and plans for coördinating all civil and military medical and allied personnel.

To broaden the powers of the Committee for Scientific Research.

To urge the Specialty Boards to re-examine their requirements with a view toward allowing credit for experience secured in private practice.

Allow me to interject here that the temper of the House was irritated by the attitudes assumed by some of the Specialty Board.

Now back to the resolutions.

One was approved to re-affirm the vote of opposition passed by the House against the policy of rebating physicians for prescriptions of any kind. That resolution was pretty strong when introduced, going so far as to request the American Medical Association to expel members who engaged in the practice. But the Resolutions Committee felt that the power of expulsion rested in the local county societies, and their recommendation was adopted.

Another to have the Committee on Medical Education and Hospitals confer with Medical Schools on the education of students to become General Practitioners, family doctors if you like, and to de-emphasize the early training for specialties. It was reported that a questionnaire had revealed that only 8% of medical students were preparing to become general practitioners.

Another to have a scientific session exclusively for general practitioners preceding or following the supplemental meeting of the House of Delegates which is held in December. It was furthermore resolved to hold this supplemental meeting of delegates and general practice session in a different section of the country each year.

It was apparent from the first session, after the addresses of President Shoulders and President-Elect Bortz that the delegates felt that measures to encourage General Practice should be introduced and supported, and that the Specialty Boards without lowering any of their standards for best quality practice should be urged to reconsider some of their qualifications for taking examinations. It was apparent also, that the nursing crisis needed immediate serious attention.

The problems are outlined already in the address of Doctor Bortz. Again I urge you to read it.

For a delegate to bring you an extensive report of the exhibits, scientific and commercial, is impossible. It was possible for me to visit the Exhibition Hall on two occasions and to observe the infinite variety of excellent exhibits. The gold medal in Group I was awarded to George E. Burch and Paul Reaser, Tulane Medical School, New Orleans, for the exhibit on "Radio-Elements and Mechanism of Congestive Heart Failure Radiosodium."

The silver medal was awarded to F. H. Fraget, P. T. Erickson and Sister Hilary Ross, U. S. Marine Hospital, Carville, Louisiana, for the exhibit on "Chemotherapy of Leprosy." In Group II the gold medal was given to George F. Cahill and Myer M. Melicow, Squier, Urological Clinic, Presbyterian Hospital, New York, for the exhibit on "Tumors of the Adrenal Gland."

The silver award to Lester Dragstedt, Paul V. Harper, Edward Woodward, E. Bruce Tovee and Augustin Rodolfo, University of Chicago, for the exhibit on "Gastric Vagotomy and the Treatment of Peptic Ulcer."

The Physicians Art Exhibit was the greatest ever. Again our prize-winning member, Dr. John Allen, was represented by two oil paintings.

In conclusion, it was a memorable occasion. My only regret is that I had only one pair of eyes, ears, legs and arms. I could have used two dozen.

CHAIRMAN COBB: You have heard the report of your Delegate to the A. M. A. Is there any discussion?

DR. ALBERT W. PLUMMER, Lisbon Falls: Mr. Chairman, I note from that report that some 4 million and several hundred thousand dollars in loose funds are in the Treasury, uninvested. I don't know how much may be invested. May I ask Dr. Foster what is the relative standing as to a year ago? Can you give me some idea?

DR. FOSTER: The amount in the Treasury has been

reduced because the income is less this year. It is in the Treasurer's Report, Dr. Plummer, and I will leave this book with Mrs. Kennard; I brought it here for that purpose. The income this year to the Association was a lot less; the profits were less. The cost of publishing the JOURNAL was a great deal more, and the labor costs were increased greatly, so that the income was greatly reduced.

DR. PLUMMER: You mean the net after expenses?

DR. FOSTER: The net income, that is right.

Now, they have set aside—I didn't mention this in the report—a sum of money to erect a new building. A committee was appointed to investigate the advisability of having new quarters, as the present quarters in Chicago are inadequate.

The invested funds are not less. That situation is just as good as it was last year. But, the profits were less.

DR. PLUMMER: One other point, Mr. Chairman. I notice a page given to Camel or some other cigarettes in the JOURNAL. It isn't quite clear to me why the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION is advertising cigarettes, any more than it should advertise liquor or soap powder. As a matter of fact, it strikes me that in the JOURNAL, there should only be advertised such things as relate directly or indirectly at least to medicine. Perhaps most of you fellows smoke cigarettes, so it is related, maybe indirectly, in that way. But, I can't see it.

I think, Tom, if you are Delegate another year, that I would be glad if you would bring that matter up.

DR. FOSTER: This is the time to do it, because there will be a meeting in December, so that while we are here at York Harbor, Dr. Plummer, if you will draw up a resolution and bring it before this House of Delegates tomorrow and have the resolution approved by this House of Delegates, I will be glad to take it to that supplemental meeting in December. Otherwise, we would have to wait a whole year before we could produce a resolution, because our State meeting comes after the A. M. A. meeting. So that if anybody wants to bring something before the A. M. A. in official meeting assembled, now is the time to do it, right here at York Harbor. And, Dr. Plummer, if you disapprove the cigarette advertising in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, now is the time to prepare a resolution and have it approved by this House of Delegates.

DR. KINGHORN: Mr. President, I think the delegation here assembled today is a darned good one. What do we care what they advertise in the JOURNAL, as long as they get paid for it?

DR. FOSTER: May I ask a question? How many delegates do we have here?

[After the delegates who voiced themselves as being present on roll call were counted, it was found there were 19.]

DR. FOSTER: We have a great quorum. The quality is good. The quantity I was inquiring about and I got my answer.

CHAIRMAN COBB: Is there any other discussion? If not, I declare Dr. Foster's report approved, as read and placed on file.

Next are the reports of the Delegates to the New England Society meetings. The first report will be from the Connecticut meeting, and I will ask Dr. Webber of Androscoggin to give us that report. [He was not present, and it was stated that his report would be given on Monday afternoon.]

Next, I shall ask for the report of Dr. George E. Young of Skowhegan, who represented us at the Massachusetts meeting.

SECRETARY CARTER: As Dr. Young is unable to be present, he has sent in the following report, which I shall read.

[Dr. Carter then read the following report:]

Gentlemen:

I beg to tender the following report of my attendance at the Annual Meeting of the Massachusetts Medical Society, at Boston, May 20-22:

All State delegates were introduced at the first general session. There was a good representation from the New England States.

The President of the American Medical Association was in attendance, and spoke at two different times during the session.

The scientific session was most interesting.

There were a few special papers, but for the most part complete subjects were covered, following through by symposium. It gave one, at the end of the session, the feeling that he was pretty well up on that particular subject.

Of course much to my own delight, chest diseases were thoroughly discussed. Don Streeter gave a nice review of his work, as well as others.

I think one of the nicest papers was given by Dr. Priscilla White, covering the different types of diabetes and their relation to the choice of treatment. This was a paper well worth reading, and furthermore its contents I believe should be adopted pretty much as a standard procedure for all diabetics admitted to any institution.

There were many other very interesting papers.

The general tone of the meeting, especially fellowship, was inspiring. There was considerable said concerning the employment of a full time information man for the Society. I got the impression that the Massachusetts Council felt that there should be more general information disseminated among the fellows. I think they are doing this a great deal by the interchange of staff members, through staff meetings, conferences and such.

General inquiry led me to believe that both the Blue Cross and Blue Shield were working out satisfactorily. The only group that I contacted that felt somewhat doubtful were the X-ray men—in fact, the X-ray group brought into the Council a complaint concerning charges fixed by the Blue Cross.

I very much appreciate the opportunity of attending this splendid meeting as your representative.

CHAIRMAN COBB: The next report will be from Dr. Kinghorn, who represented us at the New Hampshire Medical Society meeting.

DR. KINGHORN: Mr. President and members of the Maine Medical Association. This year, for the first time in many years, the New Hampshire Medical Society changed their place of meeting from Manchester down to Newcastle, at the Wentworth Hotel. They had a very interesting meeting. The State Secretary's salary was increased by the Trustees to $1,000, and that includes his travelling expenses of about $300. That isn't quite what we pay.

They had several out-of-state speakers, all of whom were very good, especially Dr. Kittredge from Boston, who gave a fine talk on Gall Bladder and discussed 200 cases of his own; this was most interesting and instructive.

In response to the introduction of delegates, I invited them to come down here to our meeting at York Harbor.

CHAIRMAN COBB: Thank you, Doctor. Our Delegate to the Rhode Island Society was Alvin Morrison, and he will now give his report.

DR. ALVIN A. MORRISON, Portland:

Mr. President and Members of the Maine Medical Association:

It was my privilege to be a delegate from the Maine Medical Association to the 136th Annual Meeting of

the Rhode Island Medical Society held at Providence, May 14-15, 1947.

At the opening meeting President Herman C. Pitts gave a welcoming address to the members of the Society. Delegates from other Societies were then recognized and welcomed. The first day's program was an interesting and instructive mixture of clinical and research subjects. That evening was the annual banquet for members and their wives. The presentation of the Charles V. Chapin Memorial Award was the feature of the evening. It was presented to Dr. Stanhope Bayne-Jones of Yale University who had presented the Charles V. Chapin oration on the Control of Typhus Fever in the program of the afternoon.

The following day a most interesting scientific program was presented both morning and afternoon.

The business portion of the meeting was not unlike our own, and in common with us, prepaid sickness insurance was a major topic. Along this line no definite legislation has been accomplished.

It was a most interesting and instructive two days and I am happy to have been your representative.

CHAIRMAN COBB: Thank you, Dr. Morrison. The next report is that of the Delegate to the Vermont Society, Dr. Flanders.

DR. MERTON A. FLANDERS, Waterville: Mr. President and members of the Maine Medical Association. The meeting of the Vermont Society took place in Burlington, last October, and the most interesting thing to me was some legislation that the Vermont State Society was attempting to pass through the Legislature. I have taken some excerpts from the various sections of this Act, and I can read this in a minute and a half. The following paper is factual only.

"The Vermont State Medical Association and its legal representatives drew up an Act, confining and regulating the practice of the healing arts. The purpose of the Act was to establish standards so that every licensed practitioner of the healing arts in the State of Vermont could conform so far as it may be possible, to the uniform standards of the professional fitness.

"Among the various sections of this Act, there were several definitions of the terms 'practice of medicine,' 'practice of osteopathy,' and 'practice of chiropractic.' "

"The State Board of Medical Examiners appointed by the Governor consist of four medical doctors, two osteopaths and one chiropractor. Its function was to draw up such rules and regulations and by-laws necessary to perform the duties and transact the business under the provisions of the law, and an Approving Authority Board, to consist of the Commissioner of Education, one M. D., one osteopath and one chiropractor, was to be formed for the purpose of listing the approved medical schools and their standards.

"The object of the act was to increase the standards of practice of the various healing arts by gradually raising the requirements of professional and pre-professional education.

"The chiropractor group will be the most affected, for the Act provided that on October 1, 1951, the chiropractor seeking a license to practice would have to have two years of college and four years of professional school, in the required subjects. The aggregate time of professional study would be 3600 hours.

"This Act was voted down recently in the Vermont State Legislature 10 to 1, and its failure to pass has been ascribed to the poorly organized effort of the Vermont State Medical Society, and the support given by certain members of the Legislature, due to chiropractors and certain other weak members of the healing arts.

"The osteopaths, while avowedly interested in raising professional standards, were indifferent to the passage of this legislation.

"At the present time, limited clinical facilities are available to the osteopaths, and that is the only deterrent that prevents them from attempting to practice all of the branches of medicine and surgery.

"Possibly this reflects the attitude of the public."

One other thing that was interesting that took place was a vote to increase the amount of money that each medical practitioner paid into the Society each year, in order that certain funds might be given to elderly doctors who had become indigent, and who, at one time, had been rather successful. And I mean that way, honorably so, in the practice of medicine.

Another thing they were concerned with at that time was how the Vermont State Medical Society could aid and help the tuberculosis survey—I should like to change that and say the X-raying of the chests of everybody in the State of Vermont. I believe that that has been taken care of subsequently in the manner similar to the practice existing here in Maine.

CHAIRMAN COBB: Thank you, Dr. Flanders.

Is there any discussion on these various reports from your delegates? If not, I will declare them approved, as given.

The next thing on our agenda is new business. Has any one any new business which they want to present at this time?

DR. CLYDE I. SWETT, Island Falls: We have heard the recommendation of Dr. Ames, Chairman of the Council, in regard to the proposed medical school for the State of Maine.

We had two major legislative acts this year, both of which failed.

We have a new Executive Secretary, who has done a splendid job in the few months that he has had to get acquainted with our program. I, personally, want to pay my respects to Mr. Payson for the fine work that he has done for the Society. I think that we can all recognize that it will take at least two years and possibly three years for any business man to know the business sufficiently to conduct its affairs properly.

Now, I feel that these two measures that we have proposed are just a starting point. There is a great deal to be done. We have learned considerable by this experience.

Our relationships with the Legislature this year have not been adverse. I think that they have been very favorable, from the reports that I have received.

I think that we owe to Dr. Edward Herlihy, Chairman of the Proposed Medical School for Maine Committee, a deep vote of thanks for the splendid personal interest and sacrifice of time that he has given to promote that part of the program.

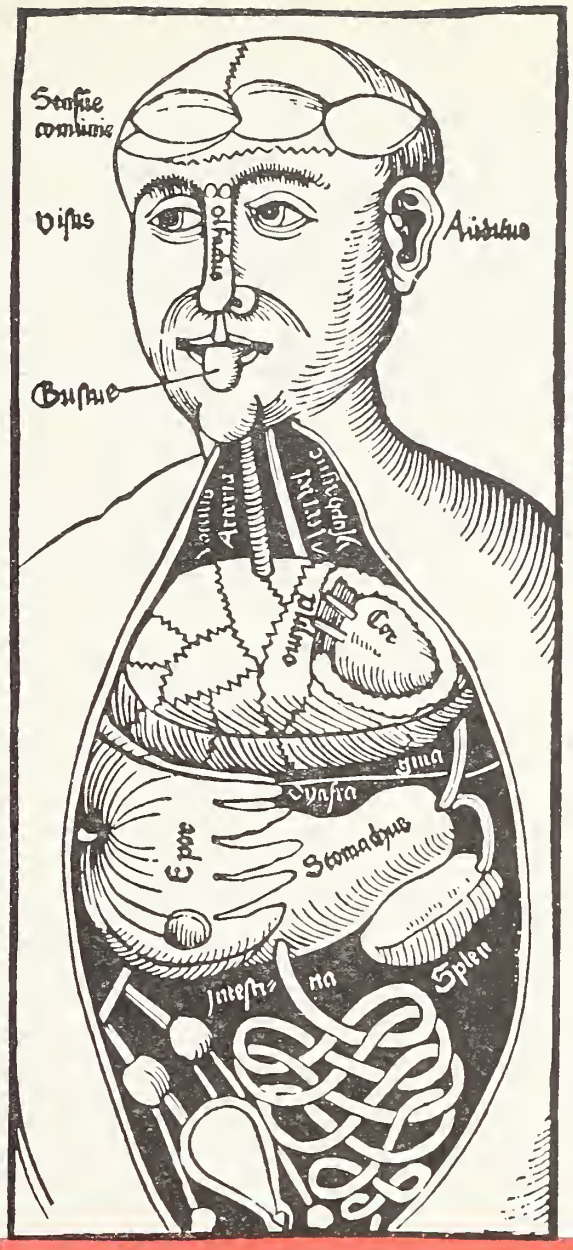
We have already gained some advantage in that we are to have a committee composed of three men from the Maine Medical Association, three trustees and three laymen.

I do feel that we should recommend as one of the men recommended by this Association, Dr. Herlihy, to represent us on that Committee. I further feel that this House of Delegates should buckle down to some hard work this coming year, and that we should also have a continuation of committee activity in regard to promoting the medical school in the State of Maine for the coming legislature next year.

As far as the medical care program is concerned, there is a great deal more work to be done there. In the first place, I feel that it is our responsibility to sell to the medical men in the State of Maine the need for it. If we find that the majority feel that we don't need the program, then let us drop it. If we feel, upon further investigation, that it is a desirable program to have, then by all means let us have active work along those lines.

Continued on page 252

Anatomic woodcut:
Title page from
Pyligk Compendium;
1516—Courtesy,
The Bettmann Archive



IN 1516:

Anatomic illustrations were crude; knowledge of the anatomy and the treatment of diseases of the heart and thoracic organs were extremely limited.

today:

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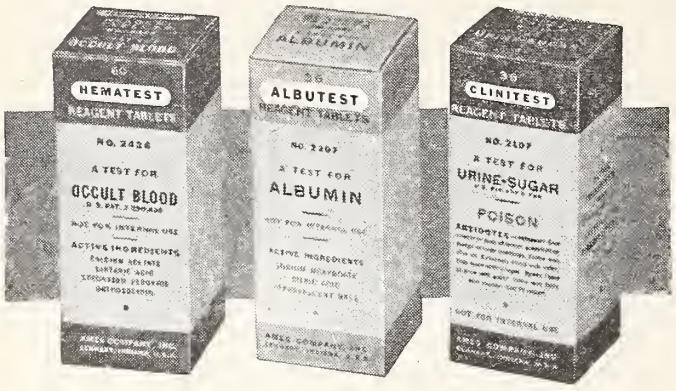
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Proceedings—Continued from page 250

First, and this is paramount, there is a necessity for educating the medical men in the State as to the need for this program. I have found, as a member of that Committee, that one of the things that was an obstacle to us, definitely, was the fact that we had definite and serious opposition in our own medical society in regard to prepaid medical care.

The other thing I found was that we hadn't laid our ground work sufficiently well. We went before the hearing of the Judiciary Committee, without well-formulated plans, without a program, ... nobody knew what he was supposed to do.

Now, those are haphazard methods, Gentlemen.

I should like to see two things done this year, if nothing else. First, to go ahead with the program that we have started; that we go on in our activity to promote a medical school for the State of Maine; and, that we revise our methods to the point where we know what we do want in regard to a medical care program for the State of Maine.

One of our major arguments was not even proposed, and that was the fact that all we were asking for was an insurance program for our own profession.

I think that if we put a little time and thought into this matter, and arranged our program suitably, there is no question but that we can go back to the Legislature another year and tell them what we want. They will know that we are not out to see how many dollars we can make and that we are truly sincere in our efforts, and that we are trying to do things for the people of the State of Maine and for their best interests.

CHAIRMAN COBB: Does anybody else have something to say?

DR. FOSTER: Mr. Chairman, inasmuch as you have ruled that a delegate has the privilege of the floor, I would like to call to the attention of the delegates a proposal made sometime ago. Now, I am entirely in accord with the remarks made by Dr. Swett. Nothing would be accomplished by the Maine Medical Association—well, I won't say "nothing" because that is strong language; but, our accomplishments will fail of achievement unless we get together more frequently and do more work.

It was proposed some years ago that the House of Delegates should have a supplemental meeting in the mid-winter and the proposal was not adopted.

I should like, in support of the previous delegate's remarks, to suggest that this House of Delegates bring to the Council the belief that it would be in the best interests of the Maine Medical Association for the delegates to have a supplemental meeting.

CHAIRMAN COBB: You don't have to do that; all you have to do is make a motion.

DR. FOSTER: Then I move that the House of Delegates vote to have a supplemental meeting, in the mid-winter.

CHAIRMAN COBB: It has already been brought before the Council that it might be a good idea to have a second meeting of the House of Delegates. I am glad it was brought up at this meeting.

DR. SWETT: I should like to second the motion.

CHAIRMAN COBB: Will you repeat your motion, Dr. Foster?

DR. FOSTER: Well, the sense of the motion is to have an extra meeting of the House of Delegates. My own objection is that there are too many things going on here at the meeting, and many delegates are anxious to go to the scientific sessions, and they are anxious to see friends and to visit the exhibits. Therefore, I move that this House of Delegates have a supplemental mid-winter meeting.

CHAIRMAN COBB: Is there any discussion? Of course, there is the other side of the question, of having the fall clinical session; the doctors are busy, no matter who they are, all over the State. Perhaps the Fall Clinical meeting this year will be in Lewiston or Portland.

DR. FOSTER: This House of Delegates could meet the day before or the day after the Fall Clinical Session.

CHAIRMAN COBB: The Council discussed today a Fall Clinical meeting, probably in November, in either Lewiston or Portland.

DR. FOSTER: I move that the House of Delegates, at the time of the Fall Clinical Session, be called into a supplemental session.

DR. SWETT: I will second the motion.

CHAIRMAN COBB: Is there any further discussion? If not, those who are in favor of the motion will please say "aye." Those opposed?

There was a chorus of "ayes" and the motion was unanimously carried.

CHAIRMAN COBB: Is there any further business to come before this meeting?

DR. MARTYN A. VICKERS, Bangor: Mr. President, it was brought up at the last meeting of the Penobscot Medical Society that it was the feeling of the members that something should be done to stimulate the MAINE MEDICAL JOURNAL. There is considerable question as to what function the JOURNAL fulfills, but at present, it wasn't the feeling of the Penobscot group that the JOURNAL fulfilled any particular function, and it was proposed that the Delegates at this meeting suggest that this House of Delegates or the Council put forth some constructive plan, either by making the editorial board more active or by asking for special papers from particular people, or in whatever way they felt was best.

This proposition is being presented by the Penobscot County group with the sole idea of improving the JOURNAL in any way that the Association, as a whole, feels best.

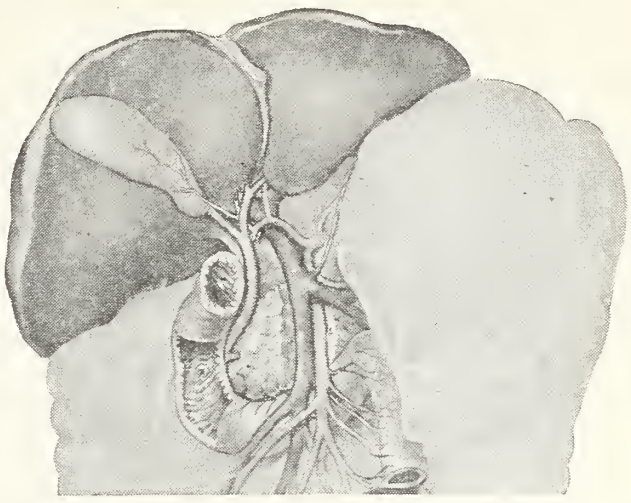
I should like to hear from some of the other members.

CHAIRMAN COBB: Does any one wish to express their sentiments?

DR. SWETT: Mr. President, if I might inject an idea—I don't want to talk too much—but this brings to my mind the possibility that probably one of the best ways of getting at this would be directly through the County Societies themselves. It would be rather hard to set up a special group, and it might tend to show discrimination in some instances. Further, it might be that after a little flurry, it would peter out for lack of material, or work an undue hardship on a few individuals.

If, however, the Editorial Board of the Maine Medical Association were to set up a group so that there would be a representative on the Board from each county society who is authorized and charged with the express purpose of gettting material out of his society for the JOURNAL, we might have a democratic way of getting material, and at the same time, stimulating, especially from your younger members, incentives to present papers from time to time.

That is, the man from each county society would be a representative on this Editorial Board, and he would make a special point of selecting papers at the meetings, or asking individuals from time to time, as a part of his responsibility, to have them prepare a good paper for the JOURNAL, and then we would have an active, coöperative type of thing that would include everybody at the same time. This would be a live-wire idea, and I think it would be an incentive to the members of the Maine Medical Association.



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CHAIRMAN COBB: Is there any further discussion?

DR. FOSTER A. SMALL, Belfast: I might say, as a matter of interest, that this matter has not been overlooked.

During the past few years, as you all know, those of you who are county secretaries, how many letters have you received from the Editor asking for papers of your speakers, and you know that you haven't been able to get them because some of the speakers have come from a distance and they have spoken extemporaneously; they have been busy and have not sent their papers in. I think that that has accounted for some difficulty in the past.

Now, so far as the future is concerned, I feel sure, and I think you will agree with our new set-up of our Executive Secretary, who will be traveling constantly, as we hope and expect he will during the coming year in order to contact the various county societies, that he will be in a position to stimulate more interest in what is going on and perhaps this will be of considerable interest in helping to improve the calibre of the papers which we are able to get.

That is a suggestion which is a little bit on the optimistic side at the present time.

CHAIRMAN COBB: I might say that your Council, in session, in increasing the salary of the Secretary-Treasurer and the Assistant Secretary, had in mind to increase the Editorial Board and to do some stimulating work so that we will have a bigger and a better JOURNAL.

Is there any motion regarding this discussion?

Is there anyone else who has anything to bring up?

DR. JAMES A. CROWE, Ellsworth: I should like to bring up the question of readjustment of the schedule of fees for the compensation cases. I understand that it has got to come through the State to do it. We, in the Hancock Society, last winter—one of our members was very burned up about such cases. This man had a bilateral inguinal hernia, on one side, and I don't remember which side, but it was complicated with femoral hernia. Whoever was in charge of the payment of the compensation cases said that it didn't make a damned bit of difference whether it was one, two or three, it was still $100.00. Our member felt that now, with everything going up, it might be well to re-examine and maybe change the schedule of fees.

I don't know just how to go about it. But, they wanted me to bring it up at this meeting.

A MEMBER: Don't you think that this will be taken care of on the insurance payments?

DR. CROWE: I don't know.

A MEMBER: There is another job for our Executive Secretary. That is one way of answering your question. He has talked with the insurance people regarding their relationships, insofar as the insurance companies enter into the compensation field. That is the State Industrial Board. I don't know that that would have to be investigated from our standpoint.

DR. CROWE: That is right.

CHAIRMAN COBB: Is there any further business to come before this meeting?

I want to say that there will be Councilors elected from the Third and Fourth Districts, and their names should be submitted to the second meeting of this House of Delegates tomorrow afternoon.

If there is nothing further to come before the meeting at this time, I will declare this meeting of the House of Delegates adjourned, until five-thirty tomorrow.

[Whereupon, the First Meeting of the House of Delegates was adjourned at 5.35 p. m.]

(To be continued in the November issue)

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OCTOBER 29 - 31

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DR. GEORGE BAEHR
New York Academy of Medicine
New York, N. Y.

DR. LOUIS A. BUIE
Mayo Clinic
Rochester, Minnesota

MR. BRADLEY DEWEY
Dewey & Almy Chemical Co.
Cambridge, Mass.

DR. L. EMMETT HOLT, JR.
New York University College of Medicine
New York, N. Y.

DR. EDWIN P. LEHMAN
American Cancer Society
New York, N. Y.

DR. MICHAEL L. MASON
Northwestern University Medical School
Chicago, Ill.

DR. WALSH McDERMOTT
Cornell University Medical College
New York, N. Y.

DR. HUGH MONTGOMERY
University of Pennsylvania Medical School
Philadelphia, Pa.

DR. HERMAN O. MOSENTHAL
Columbia University
College of Physicians and Surgeons
New York, N. Y.

DR. I. S. RAVDIN
University of Pennsylvania Medical School
Philadelphia, Pa.

DR. HARRY C. SOLOMON
Boston Psychopathic Hospital
Boston, Mass.

DR. MARION B. SULZBERGER
Columbia University
College of Physicians and Surgeons
New York, N. Y.

DR. RICHARD W. TeLINDE
Johns Hopkins Hospital
Baltimore. Md.

DR. EVAN W. THOMAS
Bellevue Hospital
New York, N. Y.

DR. EDWARD WEISS
Temple University School of Medicine
Philadelphia, Pa.

Program

WEDNESDAY, OCTOBER 29

MORNING SESSION

8.45 Registration

9.50 Assembly called to order by Dr. Leroy E. Parkins, *Chairman*

10.00 Clinical Diagnosis of Peripheral Vascular Disease — DR. HUGH MONTGOMERY

10.30 Treatment of Open Wounds of the Hand — DR. MICHAEL L. MASON

11.00 15-minute intermission

11.15 Streptomycin in Tuberculosis and Other Diseases — DR. WALSH McDERMOTT

11.45 Office Gynecology: Diagnosis — DR. RICHARD W. TeLINDE

12.15 Luncheon. Copley Plaza Hotel
National Science Foundation Legislation — MR. BRADLEY DEWEY

AFTERNOON SESSION

2.00 Office Gynecology: Treatment — DR. RICHARD W. TeLINDE

2.30 Treatment of Peripheral Vascular Disease — DR. HUGH MONTGOMERY

3.00 Principles of Management of Burns — DR. MICHAEL L. MASON

3.30 15-minute intermission

3.45 Present Status of Lobotomy and Shock Therapy in the Treatment of the Psychoses — DR. HARRY C. SOLOMON

4.15 Common Dermatologic Problems in Medical Practice — DR. MARION B. SULZBERGER

4.45 The Use of Sulfonamides and Penicillin — DR. WALSH McDERMOTT

THURSDAY, OCTOBER 30

MORNING SESSION

10.00 The Treatment of Infantile Diarrhea — DR. L. EMMETT HOLT, JR.

10.30 Office Methods for the Diagnosis of Anal Disease (Motion Pictures) DR. LOUIS A. BUIE

11.00 15-minute intermission

11.15 Management of Diabetes Mellitus — DR. HERMAN O. MOSENTHAL

11.45 Surgery of the Aged — DR. I. S. RAVDIN

12.15 Luncheon. Copley Plaza Hotel
The Problem of Cancer as approached by the American Cancer Society
Speaker: DR. EDWIN P. LEHMAN
President, American Cancer Society

AFTERNOON SESSION

2.15 Psychiatry in Medical Practice — DR. EDWARD WEISS

2.45 Office Treatment of Anal Disease — DR. LOUIS A. BUIE

3.15 15-minute intermission

3.30 The Treatment of Syphilis with Penicillin — DR. EVAN W. THOMAS

4.00 Problems of Nutrition in the Elderly Surgical Patient — DR. I. S. RAVDIN

7.00 Dinner. Copley Plaza Hotel
Address—The Continuing Education of Physicians: A forecast of imminent changes — DR. GEORGE BAEHR

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Those who have not received an application blank or who desire further information should write to the Executive Committee, New England Postgraduate Assembly, 8 Fenway, Boston 15.

Book Reviews

"New and Nonofficial Remedies"

New and Nonofficial Remedies, 1947 containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1947. Cloth. Price, postpaid, $3.00. Pp. 749. Philadelphia: J. B. Lippincott Co., 1947.

Although the latest edition of New and Nonofficial Remedies has some eleven pages fewer than the 1946 book, its increase in size, due to the heavier paper used, and its change of color—dark green to bright red — combine to make a striking contrast with the earlier annual volumes. The book is now published by J. B. Lippincott and Company, though it is still issued under the direction and supervision of the Council on Pharmacy and Chemistry. Another innovation is the relegation of the statements of tests and standards to the back of the book, which makes the text more convenient and useable for the physician, for whom it is primarily intended. It is understood that supplements to the annual volumes will no longer be issued. The physician who is interested in current acceptances can keep track of these as the descriptions are published in the *Journal A. M. A.,* or may inquire about them by addressing the Council's office at A. M. A. headquarters. Several medical and pharmaceutical journals now carry lists of currently accepted products.

There appears to be no very extensive revision in the various general articles or chapter head discussions, although several new monographs have made their appearance and others have been revised to reflect current medical opinion. One notes the appearance of a new chapter, "Unclassified Therapeutic Agents," which includes the monographs on Gold Compounds and Iodine Compounds for systemic use. This is in line with the policy adopted some years ago of classifying accepted preparations according to pharmacologic action and therapeutic use.

Attention is called to the amplification and indexing of the section devoted to the statement of the Council's Rules. This should be of great assistance to manufacturers in the presentation of products for Council consideration and is no doubt inspired by the recent marked increase in the number of pharmaceutical concerns asking Council recognition.

The descriptions of some thirteen new preparations appear in this volume. This excludes, of course, brands or dosages of already accepted agents. Among those preparations noteworthy of mention are the pertussis vaccines and vaccines representing combinations of pertussis with diphtheria and tetanus organisms; the new histamine-antagonizing agent, Benadryl Hydrochloride Elixir (Diphenhydramine Hydrochloride Elixir); Furacin (Nitrofurazone) a new topical anti-infective agent; Streptomycin; Heparin Sodium; Parenamine, a new casein hydrolysate; Thiouracil, an antithyroid agent; Naphuride Sodium (Suramin Sodium) a new trypanocide; and Tuamine (Racemic 2-aminoheptane), a new vasoconstrictor. One notes the increasing appearance of generic designations in conformance with the revised Council's rules on acceptance of agents bearing protected or trademarked names.

New and Nonofficial Remedies remains a most valuable and authoritative compendium of modern rational therapeutics. With successive editions, it becomes more useful and accessible to the physician and to all those interested in the use, preparation, or manufacture of drugs.

"Internal Medicine in General Practice"

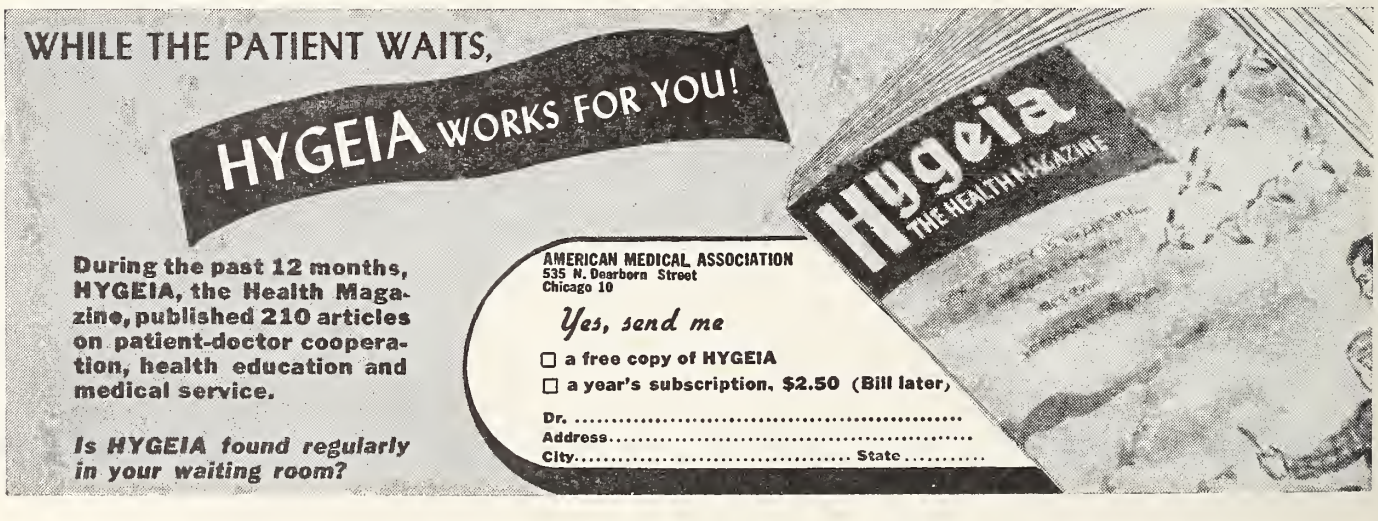
(Second Edition)

Internal Medicine in General Practice: By Robert Pratt McCombs, B. S., M. D., F. A. C. P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Second Edition. 741 pages with 122 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price, $8.00.

The second edition of this book has been completely revised, and rearranged, and much new material has been added. A chapter on psychiatric disorders has been included, also a new chapter outlining the essentials of vascular disorders of the extremities — new diagnostic methods have been included. The end of each chapter has a large list of references to stimulate further reading in each field.

It includes a very interesting chapter on disorders of the heart. Hypertension and diseases of the kidney and urinary tract. Disorders of the gastrointestinal tract. Chronic lung diseases and the use of the sulfonamides, penicillin and streptomycin.

This is a very valuable book for students and practitioners of medicine.



The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, November, 1947 No. 11

*Psychiatric Aspects of Senility**

By A. Warren Stearns, M. D., and Albert D. Ullman, M. Ed.

It has been widely recognized that older people are being committed to hospitals for mental disease in increasing numbers. There are various beliefs, which are quite widespread, as to the cause of this. One group attribute it to the increasing perplexities and hazards of modern life and assume that man is wearing out faster. Another group assign it to the relative callousness of modern youth, who are unwilling to assume the responsibilities of caring for their elders when they become helpless.

Likewise, there have been various reactions for and against this change, on the part of hospital superintendents. For instance, the Annual Report of the New Jersey State Hospital for 1946 states: "Overcrowding of patients has materially increased this year, despite a good discharge rate and an increased number on parole. The hospital is being increasingly burdened by the admission of old and feeble patients, many of them bedfast, for whom the prospect of recovery is slight. These patients are able to do little for themselves and contribute nothing to the running of the wards where they are confined, so the personnel requirements are high, while the results are practically nil. I still feel that the custodial care of the aged, whether or not they are infirm mentally as well as physically, is not one of the proper functions of a curative mental hospital with its highly trained personnel and expensive equipment for psychotherapy."[1]

On the other hand, the superintendent of a Massachusetts State Hospital gives his opinion as follows: "In considering the mental disablement of the aged, there is considerable confusion of thought in differentiating between psychotic states and those conditions of dotage which usually imply some lessening of mental efficiency and changes in disposition or temperament. That there is a merging rather than a sharp line of demarcation between these conditions may be acknowledged with some reservation. Possibly if physical survival persisted long enough there would be a very marked disintegration of all of the functions and bodily structures, leaving only an inefficient vegetative mechanism without any capacity for integrated mentation. The hair that was white would

* Read at the Annual Meeting of the New England Society of Psychiatry at Concord, New Hampshire, April 24th, 1947.

eventually disappear, the texture of the skin would change, sight would fail, cardiac and other organic activities would be ineffective and precarious. Consciousness in the ordinary sense would be suspended and the neurophysiological functions would be of the most elementary and rudimentary variety.

"Ordinarily there is not such a complete parallelism of aging of every cell in every organ of the body, and one or more of the vital systems usually breaks down more rapidly than the others, with death intervening before complete disintegration of all of these bodily components. Where the intellect and personality experience decay more rapidly than the other functions, mental disability, frequently of severe degree, supervenes. I can see no valid reason for regarding the mental disorder of old age with any repugnance or prejudice. It would seem to me that a psychotic state in an elderly individual should be regarded as a psychiatric disability and should be entitled equally to consideration and treatment by the psychiatrist and, where institutional care is necessary, in hospitals for the treatment of psychotic individuals.

"It is my opinion that . . . a senile psychotic should be regarded as entitled to attention by the same facilities that would be called on to treat younger individuals with similar mental disturbances. There is no single type of mental disability reserved for the aged. Degenerative organic brain disease, conditions due to vascular changes in the brain, conditions due to transitory impairment of the circulatory system, of the nervous system, and functionally determined mental disorders may all occur during senescence. They are inherently psychiatric problems. And the treatment facilities provided for the care of mental cases should be freely at the disposal of the aged when his condition requires such care therefrom."[2]

This study was made in an attempt to see whether or not there was an actual and relative increase in older persons to our state hospitals for mental disease, and secondly to interpret this in terms of facts. Investigation readily shows that there is a relative increase in the number of older persons committed to our state hospitals. For the year ending June 30th, 1945, 34.6% of admissions to the state hospitals of Massachusetts were over 60 years of age. Recent figures from the Worcester State Hospital of percentage of admissions 60 years of age or older are as follows:[3]

1926	28.7%
1943	33.7%
1944	35.3%
1945	41.9%

(Chart #1)

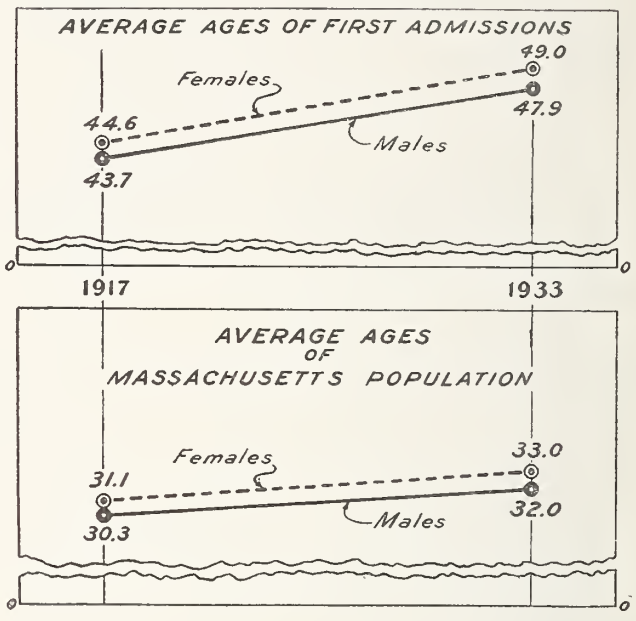


Chart No. 1

For the year 1946, 37.8% of new admissions to the Danvers State Hospital were 60 years of age or over.[4] (Chart #2). Of 818 patients

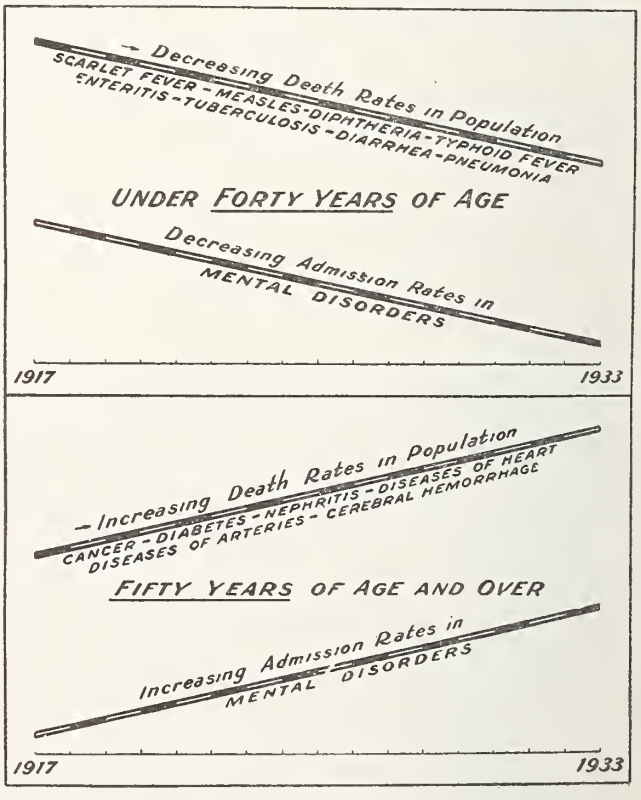


Chart No. 2

admitted to the Boston State Hospital during the statistical year 1945, 415 (180 males and 235 females) were over 60 years of age, or 50.7% of first admissions to the hospital. The breakdown of this group was as follows:[5]

56 patients	60-64 years
87 patients	65-69 years
99 patients	70-74 years
89 patients	75-79 years
49 patients	80-84 years
35 patients	85 years or over

From the above it can be assumed that there is an accelerating increase in the rate at which older persons are being committed to state hospitals for mental disease.

Our search for the meaning of this involves a certain amount of population study. In 1798 Malthus published his *Essay on the Principles of Population*[6] and thus began an interest in one of the most important problems concerning us today. The population in a primitive society is supposedly stationary; the birth rate and the death rate balance each other. However, with the advance of civilization this balance has been disturbed. Malthus called attention to the fact that population increases geometrically, while food supply increases arithmetically, and he foresaw the time when, unless action were taken to prevent, the population would be too great for the world's food supply. But there has been an abundance of food for this vastly enlarged population because, even though the population has increased rapidly, the technological advances in food production have increased even more rapidly.

Since the time of Malthus a number of things have come in to affect the stability of the population. In the first place, sanitary engineering and public health measures have tremendously augmented the life expectancy. But a few years ago, a child born healthy might be expected to live 30 years. Now a healthy female child may be expected to live 67 years. Thus the death rate has been decreased. However, in civilized societies there has been a falling off in the birth rate, with a reduction in the number of healthy children born. Yet all in all, during the last century the population has risen tremendously. In the United States, for instance, the population in 1790 was 3,929,214; in 1940 it was 131,669,275. Likewise, the population of Massachusetts during the same period, from 1790 to 1940, has increased from 378,787 to 4,316,721. The rate has been somewhat greater because of immigration. According to the 1940 census, the rate of increase in the population of Massachusetts for the preceding decade was only 1.6%, the smallest since the first census.[7]

Not only has the population increased tremendously, but there has been a change in its quality. That is, there are more older people. With the reduction in births as well as infant mortality there has been a gradual accumulation of older people. Many figures have been cited to illustrate this and many estimates as to its future progress have been made. The following two tables are typical:[8]

Proportion of our population 45 years of age and over

1860	13.1%
1880	16. %
1900	17.8%
1920	20.8%
1940	26.5%
1960	33.3%
1980	40.3%

65 years and over

1860	2.7%
1880	3.4%
1900	4.1%
1920	4.7%
1940	6.8%
1960	10.0%
1980	14.4%

This is important for many reasons. In the first place, if we consider from 20 years of age to 59 years of age as the productive period, in 1850, for every 100 such persons there were 121 in the pre-productive ages and 9 in the post-productive years. In 1940, for every 100 producers there were 63 pre-productive and 18 post-productive persons. It is estimated that by 1980 there will be 37 post-productive persons for every 100 workers.[9]

Thus it is obvious that there are more older people in the community and that the percentage of older persons is likely to increase for many years, to say the least.

However, comparative studies indicate that the rate at which older persons are being sent

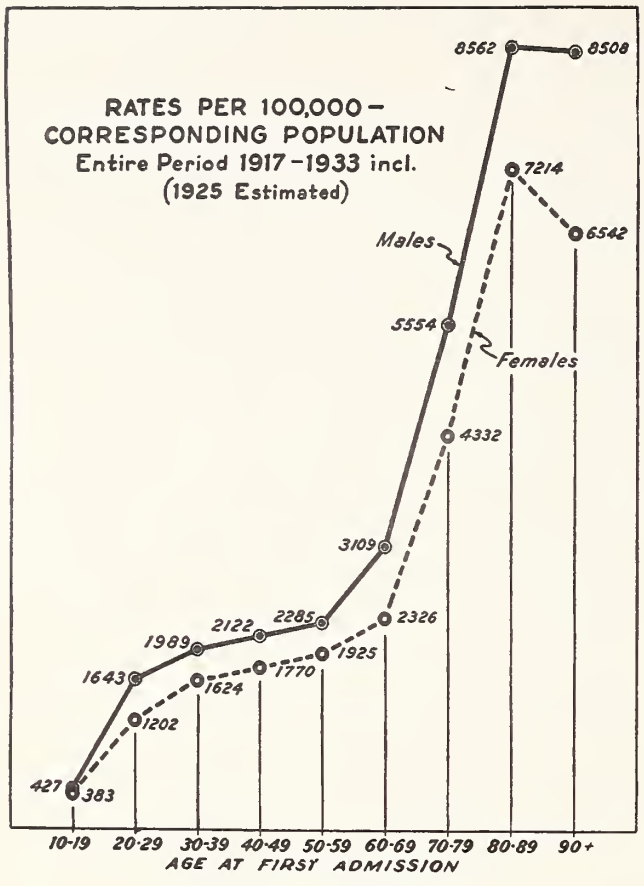
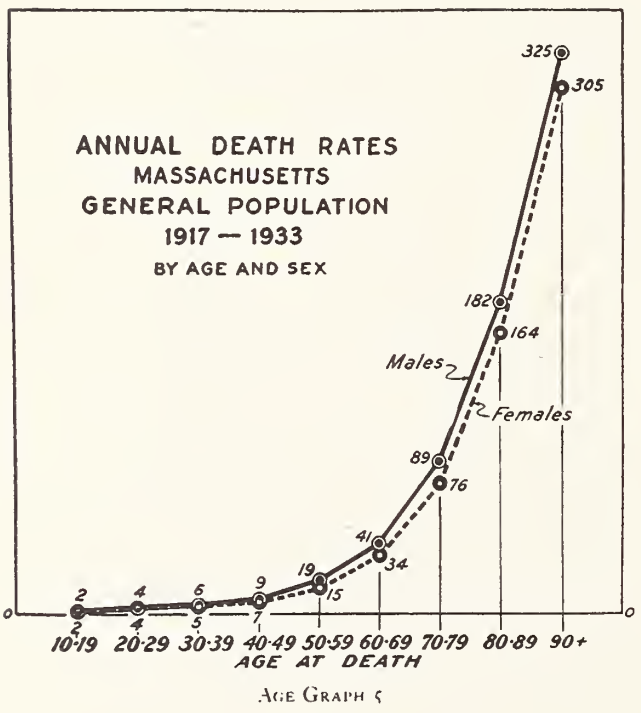


Chart No. 3



Age Graph 5

Chart No. 4

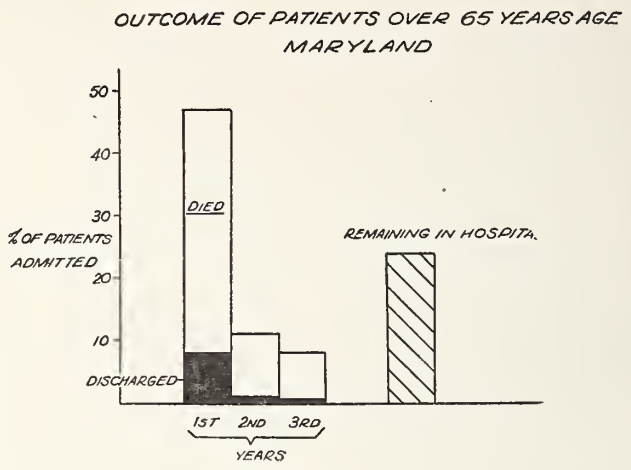


Chart No. 5

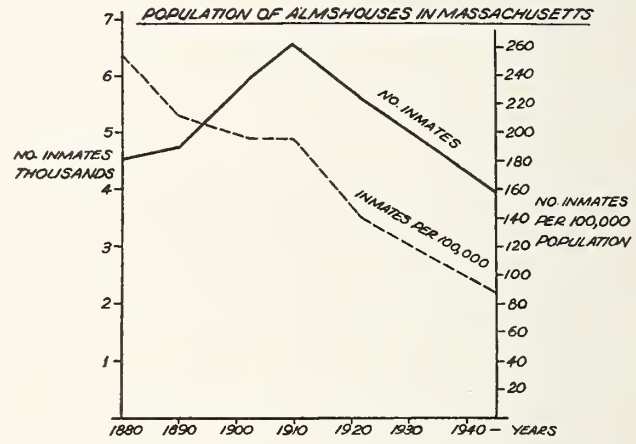


Chart No. 6

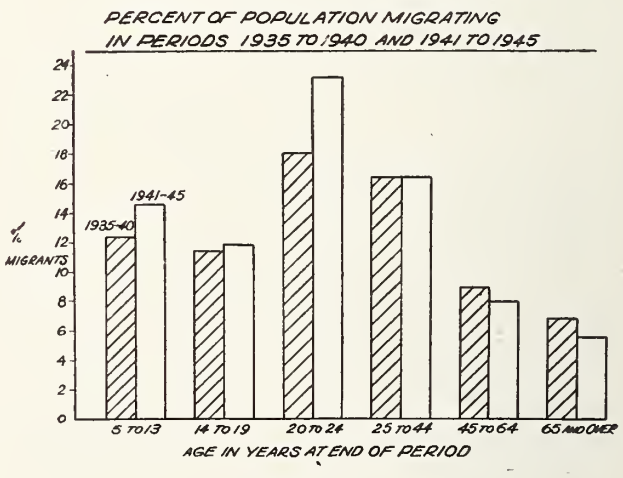


Chart No. 7

to state hospitals for mental disease is decidedly in excess of the rate of increase of older persons in the population.[10] (Chart #3). So some other cause must be sought. A comparison of the age of death from all causes and age on admission to state hospitals is instructive.[11] (Charts #4 and #5). From this it would appear that admission to a state hospital is closely related to the disintegrating process. Dr. Preston's study in Maryland[12] illustrates this very well. Of the patients admitted when they were 65 years of age or over, at the end of one year 47% had died and only 8% had left the hospital. (Chart #6). This would tend to indicate that, from the standpoint of the natural history of the organism, admission of

an old person to a state hospital is merely part of the great biological process of dying. (Chart #7).[13]

In this connection a comparison of admissions to mental hospitals in certain European countries is of interest. "The excessively high rates of first-admissions of the aged do not appear. For example, in Switzerland the first-admission age curve rises sharply from age 15 to 40 and levels off. For Norway, 1928-32, and Sweden, 1919-21, the age incidence of first-admissions rises sharply from age 15 to 35 and then gradually decreases.

"A comparison of the data from Norway and from the United States with respect to the age composition of first admissions is given in Figure 3 (Chart #8). Up to age 40 the incidence rates of Norway's first-admissions are slightly higher than those of the United States, but beyond this age the United States rates increase rapidly, while the Norwegian rates show a gradual decrease. The outstanding point of difference between the two sets of data is that beyond age 35 the incidence rate of Norway continually decreases while that of the United States increases.

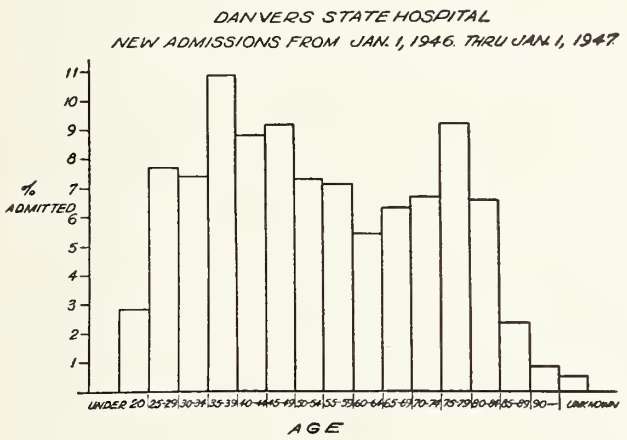


Chart No. 8

"This difference between the hospitalization rates of the older age groups rests on the fact that 1 out of every 10 first-admissions in Norway is a senile dement or a cerebral arteriosclerotic patient, while in the United States every fifth first-admission belongs in one of these two categories.

"We can not infer from these data that the aged in America are more prone to mental disease than the aged in Norway. In all probability there is no difference in the actual prevalence of the two diseases in the two countries. In the United States there is a distinct (and growing) tendency to commit aged individuals with slight mental aberrations to mental hospitals. In Norway they are 'boarded out', or sent to special institutions for the aged. The extensiveness of the former procedure is indicated by the fact that in Norway today there are as many mental patients 'boarded out' to their own families or to other private families as there are mental patients in mental hospitals."[14]

Let us, then, assume that the marked increase in admissions of older people to state hospitals for mental disease is dependent upon sociological rather than upon biological factors. No evidence has been discovered indicating an increase in mental disease among older people. Therefore it can be assumed that in the past the vast majority of older persons, whether or not they had mental disease, were cared for by their families in their homes. Of course a substantial number were to be found in almshouses and the decline in almshouse population probably is one factor in the increase in the state hospital population.[15] (Chart #9).

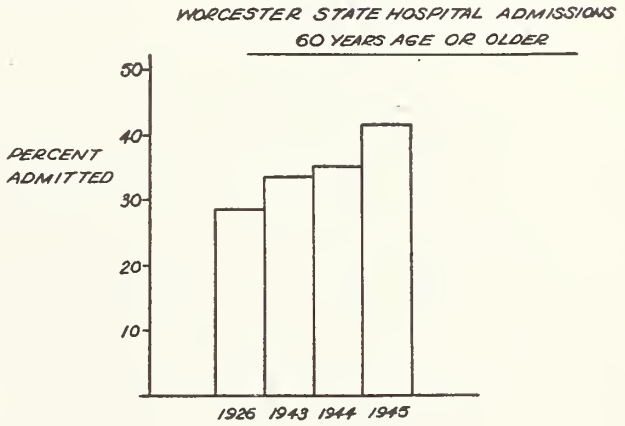


Chart No. 9

There have been a number of sociological changes which may be mentioned, which, perhaps, have a bearing upon this problem. Whereas the number of children has been smaller, the standards of their care have become higher; but with old people, the number has become greater and the standards of their care have also become higher. There is no actual census showing the physical and mental condition of old people. A recent study, however, showed that 15% of recipients of Old Age Assistance were entirely helpless.[16]

A few years ago, old people who were helpless were found in jails, almshouses and hospitals to quite an extent, but the overwhelming majority of them were cared for by their families in their homes. For many years prison and almshouse populations have been decreasing; but also the character of the home has changed. In the first place, with smaller families there is not a reserve of manpower to care for parents when they get old. Furthermore, with the increase in social mobility and so much moving around, children live quite distant from their parents and are unable to care for them. (Chart #10).[17] It will be seen that whereas 23% of

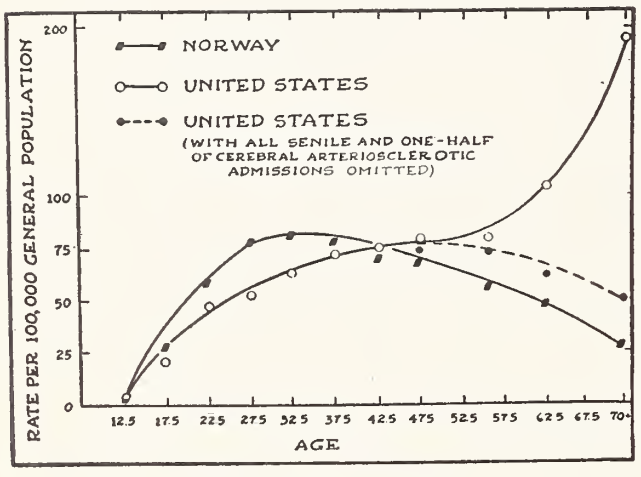


Chart No. 10

the age group between 20 and 24 years moved, only 8% of the older people migrated. In other words, the older people were left behind. Again, the houses are smaller and more people live in apartments, where there is not room for the old people. In primitive societies old people were treated with great respect and had great prestige, but there were very few of them and those things which are rare tend to be distinctive. Now that there are so many old people, it is less of a distinction and more of a burden. This may account, in part, for what seems to be lack of interest in the welfare of the aged on the part of their families.

The changes in social conditions have tended to make the care of the aged a public rather than a private matter. The passage of an Old Age Assistance Law in Massachusetts in 1931 indicates the changing custom in dealing with old folks. In 1931, the year the law was passed, there were 11,076 cases under care of the Massachusetts Department of Public Welfare. The following figures show the increase through 1942:[16]

Year	*No. of Cases*	*Year*	*No. of Cases*
1931	11,076	1937	53,951
1932	16,772	1938	66,665
1933	18,399	1939	76,482
1934	20,320	1940	83,033
1935	25,303	1941	86,820
1936	45,535	1942	87,690

This increase certainly does not indicate that there were more old people or actual dependency in Massachusetts. It merely means that people are learning to use public resources rather than their own in caring for the aged.

One corollary to the Old Age Assistance Law has been the growth of innumerable individual, private places for the care of the helpless, called "rest homes", "convalescent homes", "nursing homes", etc. There are, at the present time, 7,400 persons in such private places.[16] That their care is not all that is to be desired is frequently attested.[18]

Furthermore, the increased percentage of older persons admitted to hospitals for mental disease is merely part of a general trend as regards the care of the sick. In 1909, the total bed capacity of all hospitals in the United States, federal, state and other, was 421,065; in 1945, it was 1,739,944.[19] The increased use of hospitals is especially noticeable as regards births. In 1929, the total births in all hospitals was 621,806, while in 1946 there were 2,136,373 babies born in hospitals.[20] The increase of births in the Boston City Hospital from 1917 to 1946 is shown by the following tabulation:[21]

Births at the Boston City Hospital, 1917 to 1946, Inclusive

Year	*No.*	*Year*	*No.*
1917	179	1932	3518
1918	362	1933	3603
1919	355	1934	3380
1920	327	1935	3230
1921	406	1936	3201
1922	564	1937	3078
1923	642	1938	3284
1924	737	1939	3214
1925	494	1940	3175
1926	653	1941	2926
1927	1053	1942	2951
1928	1404	1943	2951
1930	2005	1944	2028
1931	2583	1946	2310

From this it would appear that the acceleration in rate of admissions of older persons to hospitals for mental disease is merely part of a universal sociological phenomenon by which sick persons are being cared for in hospitals rather than in their homes. No other implications appear to be justifiable. As for the future, it seems that the rate of increase in population is likely to diminish, but that at least up until 1980 the percentage of old persons will increase. Furthermore, there is still a vast residue of old persons with mental disease being cared for in their homes, many of whom will ultimately reach the city hospitals. In 1945, there were still 3,903 persons in city and town infirmaries of Massachusetts, 65% of whom were 65 years of age or over and 90% of whom were past 50. On August 1st, 1946, there were 7,400 persons in licensed homes for the aged. Many of these were mental cases and 15% were bedridden.[16] With the more rigid inspection which seems to be taking place, many of these will eventually become state hospital patients.

There is a general rule that when a service to the public, conducted under private auspices, ceases to be profitable, such a service will inevitably be assumed by the government. For instance, when there was a demand for better transportation, private enterprise started to build the early turnpikes and canals. This continued as long as they were profitable. When they ceased to be profitable, the public assumed the care of highways. When nursing homes are painstakingly inspected and adequate standards of care and protection insisted upon, they will no longer be profitable. Therefore, it may be assumed that many of the persons now cared for in such homes will ultimately become wards of the government.

Conclusions

It is apparent from this study that the increase in aged persons in state hospitals is not due to biological or even to medical causes. It represents a social change by which sick people are cared for in hospitals. There is evidence that the end is not yet in sight and that this increase will continue for many years, at least. It will be of great significance in hospital planning because many of these patients will be infirmary cases. They will not be able to travel long distances to cafeterias and rustle for their meals. They will need elevators and ramps rather than staircases and, most important of all, they will need tremendously expanding medical attention; that is, they will require more doctors, more nurses, and more hospital facilities. This, of course, immediately means more money.

During the last century there was a persistent, almost fanatic crusade for the care of grossly handicapped persons such as the blind, the insane, and the crippled. This crusade has now turned to another channel. The spokesmen for the grossly handicapped are now relatively silent and their place has been taken by spokesmen for what might be called "social betterment." It is a fact that, in Massachusetts, for a person who is totally disabled physically and mentally, requiring twenty-four hours a day nursing care, there is $8.00 per week available for such care, while if a person is perfectly healthy and, at the age of 65, elects not to work, there is little difficulty in his getting a minimum of $40 a month and an average of $52 a month. It seems worth while to say that, in our zeal for social betterment, we should not lose sight of the needs of the grossly handicapped.

References

1. Annual Report of the Managers and Officers of the New Jersey State Hospital, 1946.
2. Holt, Earl K., Superintendent, Medfield State Hospital: Personal Communication.
3. Rothschild, David, Clinical Director, Worcester State Hospital: Personal Communication.
4. Bonner, Clarence A., Superintendent, Danvers State Hospital: Personal Communication.
5. Barton, Walter E., Superintendent, Boston State Hospital: Personal Communication.
6. Malthus, Thomas R. An Essay on the Principles of Population As It Affects the Future Improvement of Society, With Remarks on the Speculations of Mr. Godwin, M. Concorcet and other writers. London: J. Johnson, 1798.
7. Statistical Abstract of the United States Census. Washington: United States Printing Office, 1944.
8. Klumpp, Theodore G.: Is Man's Useful Life Ended at 65? Reprint of text of a paper read at the Annual Meeting, American Public Health Association, Cleveland, Ohio, November 14, 1946, under the title "Care of the Aged and Chronically Ill."
9. Boudreau, Frank G., and Kiser, Clyde V.: Population Trends and Programs of Social Welfare. Collection of papers from *Milbank Memorial Fund Quarterly*, Vol. 18, Nos. 3 and 4, pp. 189-221; 345-402, July and October, 1940. Preface.
10. Dayton, Neil A.: New Facts on Mental Disorders: Study of 89,190 Cases. Springfield, Ill.; Baltimore, Md.: Charles C. Thomas, 1940, p. 59.
11. *Ibid*, pp. 52, 55.

Continued on page 267

*Narcolepsy, Cataplexy and Epilepsy**

Report of a Case

Harry Blotner, M. D., Boston, Massachusetts, and Melvin Bacon, M. D., Sanford, Maine

Narcolepsy is an uncontrollable tendency to attacks of deep sleep of short duration. Cataplexy is a sudden weakness and loss of muscle tone induced by laughter or emotional excitement. The association of narcolepsy, cataplexy, and epilepsy is rare, although narcolepsy and cataplexy are frequent concomitants. A case exhibiting these three conditions with noteworthy response to therapy is reported below.

Case History

Mr. P. A., a twenty-nine-year-old electrical service man, was first seen on December 14, 1944, with the complaint of falling asleep spontaneously, sudden weakness, sweating on the left side of the body, and twitching on the left side of the face, left arm, and left leg. His illness began at the age of twelve years, when he first noticed a tendency to fall asleep spontaneously. He commonly fell asleep in the middle of a conversation, while sitting or sometimes while standing. In the course of the years, the sleep tendency increased.

During the previous four years he had had attacks of muscular weakness, in which he would fall to the ground. These were precipitated by laughing, crying, or any emotional strain or surprise. During these attacks he felt very weak and, although conscious, was unable to move or talk. He recovered spontaneously in five to fifteen minutes. During the attacks, spontaneous involuntary movements of the mouth, and vibrations of the lower jaw occurred. The jaw movements frequently occurred when talking. Convulsive twitchings of the left arm and occasionally of the left leg and frequent episodes of sweating of the left side of the body were noted. During the previous year, he took 40 mg. benzedrine daily which alleviated the weakness and made him feel better for two or three hours. He also had some impairment of vision which necessitated the wearing of glasses.

The past history revealed mild asthma since childhood; pneumonia three years previous to admission and repair of an umbilical hernia eight years previous to admission. He had been hit by an auto four and one-half years before admission, which resulted in a laceration of the forehead. He was unconscious for thirty minutes and subsequently had a headache for several days. There were no signs of fracture or inter-cranial bleeding then while in the hospital.

The family history revealed that his father had diabetes and his mother was hypertensive. One sister died of multiple sclerosis at the age of thirty-five years, and another sister had hypothyroidism. He had been married for eight years, and his wife was underweight. He has one child, age nine years, who was a mild diabetic.

Physical examination revealed a well-developed and somewhat obese male in no apparent distress. The blood pressure was 134/90, the pulse was 72, and respirations 16. His height was 66 inches and weight, 181 pounds. The general physical and complete neurological examinations were negative.

Laboratory Data

The urine was negative. The red blood count was 4,700,000. Hemoglobin 90% and white blood count 8,000. The differential was normal. The blood cholesterol was 312 mg. per 100 c.c.. The Hinton and Kahn tests were negative. The basal metabolism was -1%. A lumbar puncture was performed and the dynamics were normal. The spinal fluid was clear, colorless, and showed the following: cells 0; globulin negative; total protein 33mg. %; sodium chloride 717 mg. %; gold sol normal.

X-rays of the skull showed normal bones. The anterior and posterior clinoids were normal. The pineal body was in normal position

*From the Medical Service of the Beth Israel Hospital, Boston.

and there was no evidence of unusual calcification or vascular markings. Electroencephalograms and pneumoencephalograms were taken, and the reports and diagnosis are illustrated below.

Diagnosis

The diagnosis appeared to be narcolepsy, cataplexy, and Jacksonian epilepsy. Pneumoencephalograms were essentially negative, although the ventricles were not well-filled with air.

Electroencephalograms

Electroencephalograms also were made. These are graphic records of electrical disturbances arising in the brain and are analogous with the electrocardiagram which is the record of the electrical action current associated with the contraction of the heart. In general, electroencephalograms of normal persons have certain basic features in common. Any change in the electrical activity, either qualitative or quantitative, implies some change in the physiological activity of the brain.[1, 2, 3]

Electroencephalograms in this case showed tracings which were consistent with epilepsy and narcolepsy. Illustrations of these are given in the accompanying charts.

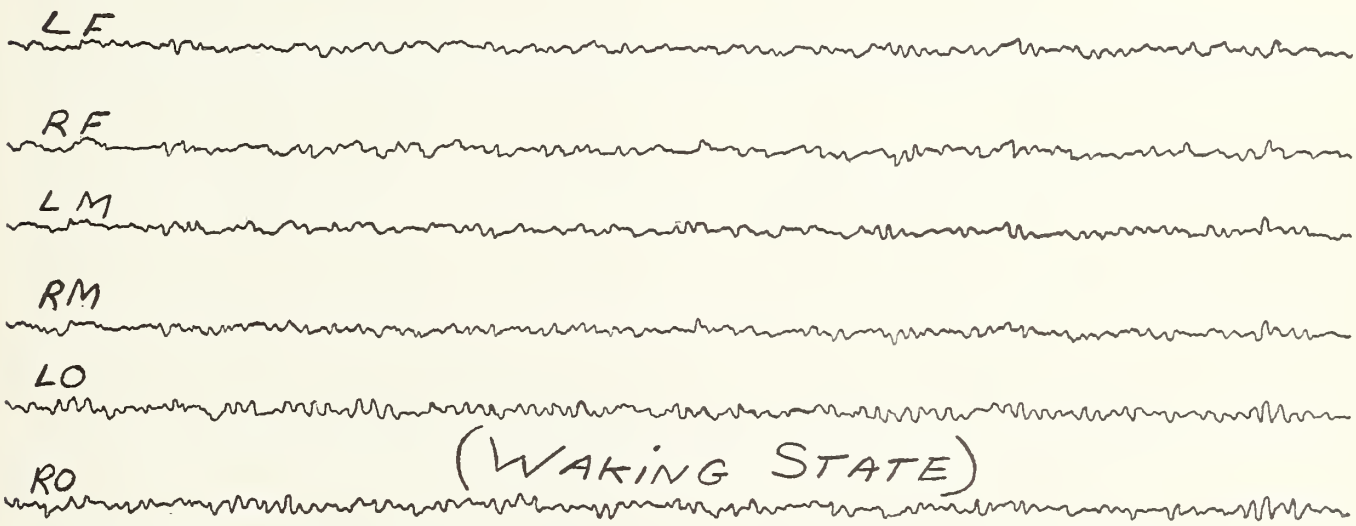


CHART 1A

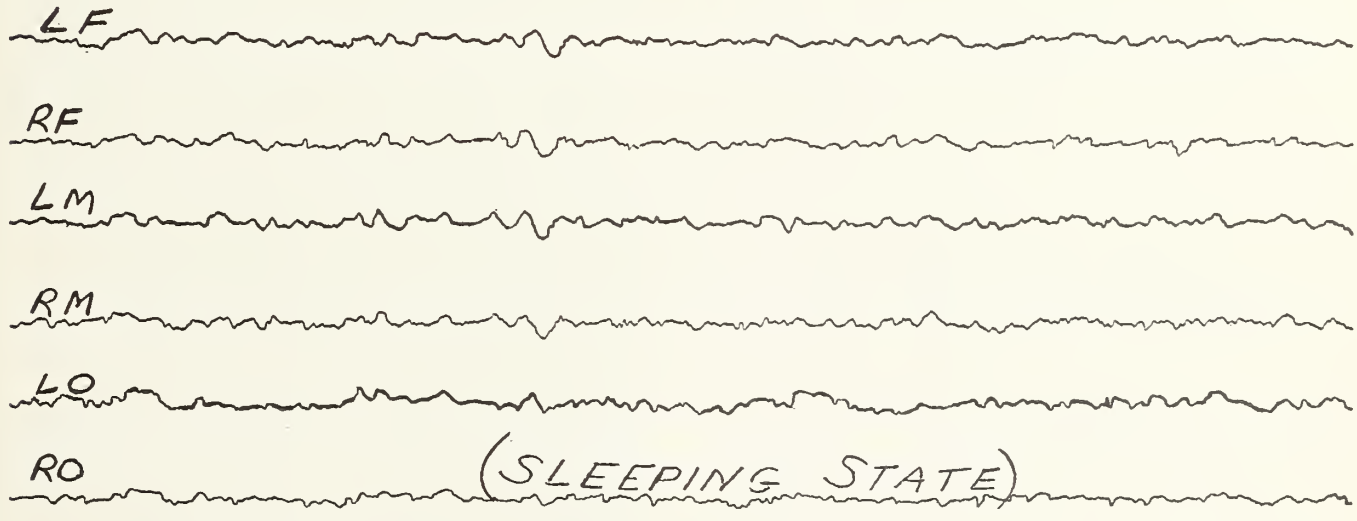


CHART 1B

LEGEND

Chart IA and B: Low voltage, slightly irregular tracing with intermittent alpha rhythm of normal frequency, appearing in the occiput. A strong sleep tendency is manifested early in the recording, and the patient quickly reaches the deeper levels of sleep. Slight voltage asymmetry appears occasionally posteriorly, the left hemisphere showing the higher voltage.

Consistent with narcolepsy. No clear focus.

The electroencephalograms were performed on five occasions and they were of special interest because they showed no changes in their pattern even when the patient was relieved of his symptoms.

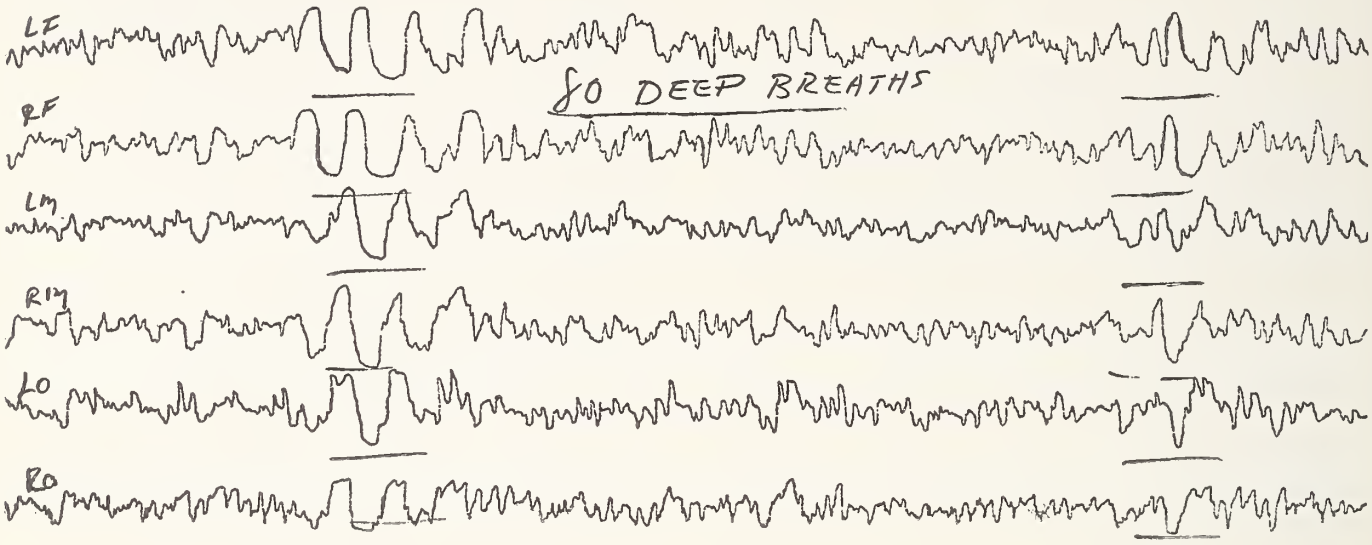


CHART 2A

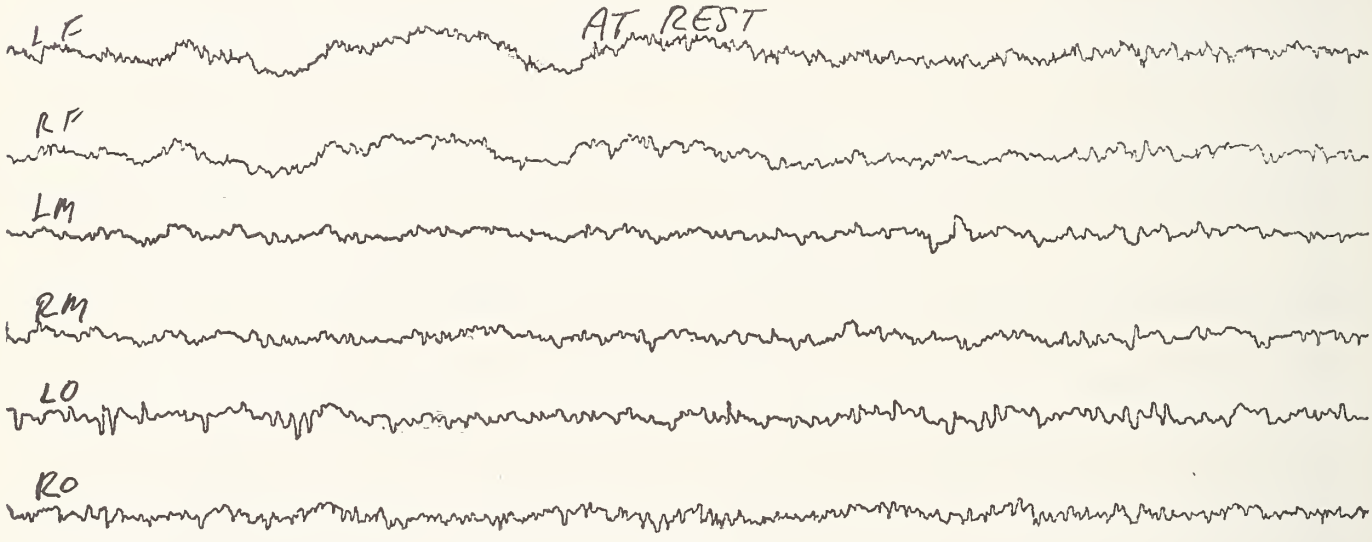


CHART 2B

LEGEND

Chart IIA and B: Irregular low voltage record, with intermittent alpha. The patient was drowsy only on one occasion for a short period. He did not fall asleep as in the previous record, but remained awake during the recording. During over-breathing, there was a marked build-up of potentials with episoditic high-voltage discharges appearing after sixty deep breaths. These were diffuse and not localized and indicate a definite instability, consistent with epilepsy.

Treatment and Progress

The patient had been taking 40 mg. benzedrine sulphate daily with amelioration of symptoms. Inasmuch as he had epilepsy, pneumoencephalograms were made, not only for diagnosis, but also for a possible therapeutic effect. This procedure has been known to relieve epileptic spells for considerable periods of time. He was also instructed to take one and one-half grains of dilantin sodium, three times a day, along with benzedrine. However, the need for these drugs was short-lived. He experienced such extreme relief from the narcoleptic, cataplectic, and epileptic seizures shortly after the pneumoencephalography that he required only one and one-half grains of dilantin sodium daily and no benzedrine. When he took large doses of dilantin sodium, he developed bleeding of the gums which was relieved when the dosage was decreased to one and one-half grains a day

and when 100 milligrams of ascorbic acid was taken five times a day. A dose of one and one-half grains of dilantin sodium daily is all that is necessary for complete relief of symptoms.

The patient's course has been striking. Two years have elapsed and he has had no more seizures of any type. The left-sided sweating and the periodical left-sided facial spasm and twitching of the left arm and leg have disappeared. He is able, at present, to do more than he has ever done before. He stays up late at night and works very hard and holds one full-time position and a part-time job. He feels well and also has noted much improvement in vision, for he needs no glasses. This alleviation of symptomatology commenced shortly after pneumoencephalography and has continued up to the present. The cause for relief of the symptoms is conjectural. However, it is possible that the injection of air during the process of pneumoencephalography caused the tearing of meningeal adhesions, or corrected a partial block in the spinal fluid system.

Conclusions

This paper presents an unusual case of a man having narcolepsy, cataplexy, and Jacksonian epilepsy as clinical concomittants.

The progress of this case is of special interest because relief of the symptoms appeared to follow a pneumoencephalogram which was performed on him.

Bibliography

1. Gibbs, F. A.; Davis, H.; and Lennox, W. G.: The Electroencephalogram in Epilepsy and in conditions of Impaired Consciousness. *Arch. of Neurol. and Psychiat,* 34:1133, 1935.
2. Davis, H.: Electrical Phenomena of the Brain and Spinal Cord. *Annual Review of Physiology,* 1:345, 1939.
3. Davis, H.; and Davis, P. A.: The Electrical Activity of the Brain; Its Relation to Physiological States and to States of Impaired Consciousness. *The Research Publications of the Association for Research in Nervous and Mental Diseases,* 19:50, 1939.

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12. Camargo, Oswaldo, and Preston, George H.: What happens to patients who are hospitalized for the first time when over sixty-five years of age. *Am. J. Psychiat.,* 102: 168-173, September, 1945.
13. Dayton, Neil A.: *Loc. cit.,* p. 65.
14. Landis, Carney, and Page, James D.: Modern Society and Mental Disease. New York: Farrar & Rinehart, 1938, pp. 34-36.*
15. Paupers in Almshouses, 1923. U. S. Bureau of the Census. Washington: U. S. Printing Office, 1925; and Statistical Abstract of the United States Census. Washington: U. S. Printing Office, 1944.
16. Tompkins, Patrick A., Commissioner of Public Welfare, Commonwealth of Massachusetts: Personal Communication.
17. Shryock, H. S., Jr., and Eldridge, H. T.: Internal migration in peace and war. *Am. Soc. Rev.,* 12: 27-39, 1947.
18. Griffin, John J.: Sheltered care for the aged. *Survey Midmonthly,* 81: 323-326, December, 1945. —New enthusiasms and ancient abuses. *Public Welfare,* 5: 68-70, March, 1947.
19. Hospital Service in the United States. Twenty-Sixth Annual Presentation of Hospital Data by the Council on Medical Education and Hospitals of the American Medical Association. *J. A. M. A.,* 133: 1066, April 12, 1947.
20. *Ibid,* p. 1074.
21. Manary, James W., Superintendent and Medical Director, Boston City Hospital: Personal Communication.

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* The author wishes to thank the authors, book and publisher for permission to use Fig. 3 from Landis and Page's *Modern Society and Mental Disease,* published by Rinehart & Company, New York, 1938.

Clinico-Pathological Exercise

Medical Case Presented at the Eastern Maine General Hospital, Bangor

Dr. George Robertson, Presiding

Edited by Joseph E. Porter, M. D., Portland

Present Illness: A 63-year-old married white man was admitted to the Eastern Maine General Hospital complaining of severe headaches. For three to four weeks prior to admission the patient had experienced sharp pains over the right frontal region extending over the right temporal region and the region of the right mandible. The pain was intermittent in character but would appear daily after he moved about for a while. He has been taking "anacin," two pills daily, which makes him feel "dopey."

The patient has had a persistent cough, is easily fatigued and has had occasional hemoptysis . He has lost weight recently but has had no night sweats. His appetite has been good. His bowel movements have been regular.

Past History: Many years ago patient had "drainage of empyema" on left side. One year ago he was admitted to this hospital with a penetrating peptic ulcer which responded to medical treatment. About 6 months ago he was told that he had active tuberculosis and since that time he has been living at the sanatorium. He has never had a positive sputum. He has had occasional dizzy spells and blurring of vision. Recently, there has been an increase in tinnitus on the right side.

Physical Examination: Examination reveals a slim, elderly male. Temperature 96.2°F, pulse 72. Pupils are miotic, regular and react to light. E. O. M. are normal. The heart appears slightly displaced to the left and the sound are normal.

No murmurs are heard. The right lung appears somewhat dull to percussion, and breath sounds and voice sounds are not transmitted. The left lung reveals normal breath sounds and voice sounds. There are no rales. The abdomen is flat and relaxed with no palpable masses. No reflex changes are observed on neurologic examination.

Laboratory Findings:

Urine: Amber, slightly cloudy, acid, 1.015, slight trace of albumin, negative sugar, occasional hyalin cast, and a few pus cells.

Blood: Hh: 12.5 gms., RBC 5,770,000, WBC 13,100, Polys 76%, Bands 2%, Lymphocytes 22%, NPN 43 mgm/100cc. Febrile agglutinations negative. Kahn and Hinton negative. Blood sedimentation rate 26mm per hour.

Gastric contents: No tubercle bacilli seen.

X-rays: On admission revealed a pneumothorax on the right with about one-third collapse of lung. The upper lobe appeared uniformly compressed and consolidated. The left lung showed some mottling of the peri-bronchial structures without definite intrinsic pathology although there was moderate fibrous reaction in the left apical region. X-ray of skull showed no displacement of the calcified pineal body.

Lumbar Puncture: I. P. 330mm. water; 7cc. of fluid withdrawn. Final pressure 170mm. water. Two lymphocytes. Protein 157mgm./-100cc. Chlorides 650mgm./100cc. Colloidal gold reaction 1112,333310. Wasserman negative. No tubercle bacilli found.

Tuberculin test one week after admission was interpreted as strongly positive.

Course in Hospital: Patient gradually became less responsive with frequent spells of delirium. His appetite became poor and he became more emaciated and had occasional bouts of fever up to 101°F. The patient expired on the eighteenth hospital day.

Discussion

Dr. Sam Wagner: I think from the outset we can say this patient had disease involving the lungs and the central nervous system. We

have to decide in the course of making a diagnosis whether this is all one process or more than one. He was admitted to this hospital with a chief complaint of severe right-sided headache. Along with this affliction he had occasional dizzy spells, blurring of vision and ringing in his right ear. This set of symptoms would lead one to think there was an abnormal process going on in his brain. The first possibility would be a tumor of some sort and a second would be an inflammatory process. Physical examination and X-ray are negative neurologically. An lumbar puncture reveals a high pressure, elevated proteins and chlorides on the low side of normal. The absence of cells would tend to rule out a diagnosis of meningitis, although a tuberculous meningitis can give a spinal fluid with few cells. In tuberculosis the chlorides should be lower. The serology of both the blood and cerebrospinal fluid were negative, and the gold sol curve is not a paretic one. Syphilis is apparently not the causative agent. It looks as if the brain lesion can be localized to the right side from the presenting symptoms, however, the course in the hospital gives no further evidence of the development of other signs and symptoms which would offer some clue as to its whereabouts. Irritation in the region of the cerebello-pontine angle would give tinnitus headache and pain in the lower jaw, but often it is impossible to localize a brain lesion by the symptoms alone.

The lung findings have to be considered and correlated if possible with those of the brain. The clinical picture which led to his admission to a tuberculosis sanatorium is not clear. He had cough, easy fatiguability and hemoptysis and a positive tuberculin test. On admission to this hospital there was evidence of a pneumothorax, probably artificial, of the right lung and this was confirmed by X-ray. X-ray also showed consolidation of the right upper lobe. The left lung was not remarkable except for some mottling and some scarring at the apex.

As to the cause of this picture the acute diseases such as pneumonia and infarct can be ruled out. The history is of too long standing. Lung abscess and bronchiectasis don't fill the bill well either. This could be one of the fungus infections and that is impossible to rule out. I think the diagnosis rests between tuberculosis and bronchogenic carcinoma. The signs and symptoms could go with either. No positive sputa were found. On the other hand a tuberculin test was strongly positive which may or may not indicate an active tubercular process. Before considering a final diagnosis an attempt should be made to tie up the lesions of the lung with those of the brain. Perhaps they are separate entities. Other possibilities would be either tuberculosis or bronchogenic carcinoma involving the lung plus a primary tumor of the brain, possibly arising at the right cerebello-pontine angle. The final course of the disease does not fit this picture. One would not expect it to end so rapidly.

I think the diagnosis rests between a primary carcinoma of the lung with metastasis to the brain and a pulmonary tuberculosis with extension to the central nervous system. The hospital course and death seem to fit an infectious process more closely. There is no evidence of increasing neurological signs as one would expect in a brain tumor. The patient spiked a low grade fever was delirious and went into coma and died. The cerebro-spinal fluid fits an infectious process with a meningitic gold sol curve and moderately high protein. I think the final diagnosis is pulmonary tuberculosis with involvement of the central nervous system in the form of a meningitis with the formation of a tuberculoma in the region of the cerebello-pontine angle.

Dr. Robertson: Would you like to see the X-rays?

Dr. Hugh Smith: The films of the sinuses are non-contributory. The skull films reveal a small amount of calcification in the region of the sella turcica which probably represents calcification in the internal carotid artery. In the lateral view the calcified pineal body falls within normal limits of mensuration by measurement (Vastine and Kinney). In the Ap and Pa views the pineal gland is displaced 1cm. to the left of the mid line.

A single Pa film of the chest taken May 20, 1946, reveals linear fibrosis extending upward and outward from the right hilus, associated with either cavity formation in the apex, or small pneumatoceles. Throughout most of the lobe there is definite pneumonic infiltration not sharply defined, and of non-homogeneous density. The right hilus is elevated and the trachea deviates to the right. It is impossible to tell

whether or not the hilar nodes are enlarged on the right. The right lower lung field, and entire left lung fields are clear. There is adherence of the lateral portion of the left leaf of the diaphragm to the lateral chest wall with pleural thickening in the costophrenic angle. The chest findings are typical of a long standing fibrocystic right upper lobe pulmonary tuberculosis with reactivation of the process.

Films of the chest taken several months later reveal the presence of a right pneumothorax with partial collapse of the right middle and right lower lobes. The right upper lobe is partly collapsed, but appears uniformly and homogeneously dense, with no air in it whatever, no evidence of cyst or cavity formation, and partially held upward by adhesions to the apex. The uniform density of the right upper lobe is compatible with bronchial obstruction, absorption of air, and atelectasis of the lobe. The trachea still deviates a little to the right, and the right hilus is still elevated.

The findings in the chest and skull are compatible with a pulmonary tuberculous lesion, and a tuberculoma of the right temporal lobe or parietal lobe. Primary neoplasm of the lung with metastasis to the brain should be considered, but the initial film prior to the pneumothorax is much more suggestive of pulmonary tuberculosis of the right upper lobe than it is of neoplasm.

Question: Why does Dr. Wagner think the cerebral lesion is located on the right side?

Dr. Wagner: Because of the pain on the right side of the head and face and because of the right-sided tinnitus.

Question: Are the cerebrospinal fluid findings consistent with tuberculous meningitis?

Dr. Wagner: The chlorides are not as low as one might expect. The cell count is not elevated. One would expect it to be.

Dr. Wadsworth: The discrepancy between the high spinal fluid protein and the low spinal fluid cell count is significant. If a meningitis or encephalitis is sufficiently active to produce a protein of 157mgm./100cc. there should be a fairly marked pleocytosis. This discrepancy argues against an intracerebral inflammatory process.

Question: Will metastatic tumors give an elevation of the total protein?

Dr. Robertson: Yes, an elevation of the total proteins is most apt to be seen in supratentorial tumors.

Dr. Wadsworth: Other factors may affect the total proteins. Tumors causing destruction of cerebral tissue rather than compression of cerebral tissue may produce an elevation of the total proteins. Tumors situated near the ventricles may be responsible for a pleocytosis.

Question: What would the findings be in a brain abscess?

Dr. Wadsworth: Unless the abscess is deeply situated away from the ventricular or piaarachnoid surfaces one would expect a pleocytosis with polymorphnuclear leucocytes predominating, even though the abscess did not extend to the surface.

Dr. Robertson: Are there any other expressions of opinion?

Dr. Lloyd Brown: The failure to find tubercle bacilli in the sputum and gastric washings in the presence of hemoptysis is against the diagnosis of tuberculosis in spite of the positive tuberculin reaction. The lack of cellular reaction in the spinal fluid is against tuberculous meningitis. The increased density of the collapsed right upper lobe is consistent with bronchogenic carcinoma. Metastases from bronchogenic carcinoma to the brain are common. Many of these patients are first seen because of their cerebral symptoms. Some of them have been operated upon for brain tumor and histologic study of the tumor has led to the discovery of the primary tumor in the lung.

Question: What are the spinal fluid changes in tuberculous meningitis?

Dr. Robertson: The fluid is usually under increased pressure and shows a pleocytosis that may be predominantly polys or may be predominantly lymphocytes. The total protein is elevated. The most characteristic finding is shown by serial lumbar punctures which reveal progressively decreasing chlorides followed by progressively decreasing dextrose levels. Cases of purulent meningitis are more apt to show an early decrease in dextrose with only moderate decrease in the chlorides.

Question: Does one always find a pellicle in the spinal fluid of tuberculous meningitis?

Dr. Wadsworth: This is not always found in

tuberculous meningitis and may be produced in other conditions. The formation of the pellicle may be delayed. If one suspects tuberculous meningitis one should allow a portion of the fluid to remain undisturbed in a test tube for twelve or twenty-four hours. If a pellicle forms, the pellicle should be examined for the presence of tubercle bacilli. They are frequently found in the pellicle when they are not found in the centrifuged sediment.

Question: Isn't this a luetic type of gold sol curve?

Dr. Wadsworth: This is a mid-zone type of gold sol curve to which the term luetic type was formerly applied. It is preferable to designate it as a mid-zone curve because it is found in many types of nervous disorders other than those due to syphilis. It may be found in tabes, non-luetic meningitis, encephalitis, multiple sclerosis, brain tumors and other conditions.

Question: What fraction is responsible for the production of a mid-zone gold sol curve?

Dr. Wadsworth: As far as I am aware this type of reaction is not dependent upon the increase of any one fraction of the spinal fluid but is rather dependent upon an imbalance of albumin and globulin fractions which disturb the stability of the colloidal solution.

Question: Is it sound to make a diagnosis of bronchogenic carcinoma in the absence of cachexia and anemia?

Dr. Robertson: Many of the patients with bronchogenic carcinoma fail to show systemic manifestations of the disease. This is one reason why the diagnosis is frequently made too late to be of aid to the patient.

Question: Could this patient have had bronchiectasis develop as a result of his old pulmonary infection which resulted in the empyema of his left chest? A brain abscess might follow the bronchiectasis.

Dr. Robertson: This should be considered but seems unlikely with his present right upper lobe pathology. Dr. Wadsworth has discussed the spinal fluid findings in relation to brain abscess and that, too, seems unlikely.

Question: Could he have had pulmonary tuberculosis and developed a subdural hematoma which might account for his cerebral signs and symptoms?

Dr. Robertson: The cerebral symptoms and spinal fluid findings observed here might be produced by a subdural hematoma, but we have no history of injury and we prefer to explain the whole picture on a single diagnosis whenever possible.

Dr. Wagner's Diagnosis:

Pulmonary tuberculosis with tuberculous meningitis and tuberculoma of right cerebellopontine angle.

Alternative Diagnosis:

Bronchogenic carcinoma with metastasis to right cerebral hemisphere.

Pathologic Diagnosis:

Bronchogenic carcinoma with metastasis to right temporal lobe.

Pathologic Discussion

Dr. R. C. Wadsworth: Post-morten examination revealed a thin elderly male. The left pupil measures 0.4cms. in diameter. The right pupil measures 0.3cms. There were healed oblique scars in the inguinal regions. There was an old healed irregular scar in the left ninth interspace, probably the site of empyema drainage. There was no free fluid in the peritoneal cavity or in either pleural cavity. There were dense fibrous adhesions surrounding the right upper lobe and a moderate number of firm fibrous adhesions at the left apex. The right lung weighed 945gms. The left lung weighed 350gms.

The right upper bronchus was completely obstructed by a large firm tumor mass measuring 2.8cms. in diameter. In a fan-shaped area radiating from this tumor the upper lobe was moderately firm, greyish-white and interspersed with soft necrotic areas. The bronchi were filled with mucoid material. There was moderate scarring over the pleural surface. The lymph nodes at the hilus were large, moderately firm and greyish-white. No tumor tissue was seen in the other lobes. There was pleural thickening of the left apex. Microscopically the tumor was an adenocarcinoma diffusely invading the right upper lobe with numerous scattered areas of necrosis. The tumor probably arose from the bronchial epithelium. A terminal bronchopneumonia was present in the other lobes of both lungs. It appeared most pronounced in the right lower lobe. There was no

demonstrable active tuberculosis in any of the sections.

Sections of the heart revealed slight atherosclerosis of the coronary vessels. Sections of the kidneys revealed moderate arterio-sclerotic nephrosclerosis. There was moderate chronic congestion of the spleen with slight deposition of hemosiderin.

Upon opening the dura there was marked flattening of the convolutions and narrowing of the sulci. The brain weighed 1520gms. and appeared assymetrical. There was a marked bulging of the mid-portion of the right cerebral hemisphere. The vessels at the base of the brain were moderately sclerotic. Multiple frontal sections revealed an irregular, moderately firm tumor mass measuring 5.0cms. in diameter quite sharply differentiated from the surrounding brain tissue situated in the anterior portion of the right temporal lobe. There was a greenish fluid exuding from the cut surface of the tumor. The right lateral ventricle was moderately compressed. The left lateral ventricle was moderately dilated. There was marked edema throughout the right hemisphere. The tumor perse did not seem to press on either the fifth or eighth cranial nerves. Histologically the tumor resembled the primary tumor of the lung and showed numerous areas of necrosis.

Metastatic tumors of the brain comprise approximately 4.2% of brain tumors seen in a neurosurgical clinic. They are usually carcinomas. Of these, metastases from bronchogenic carcinoma are by far the most frequent, comprising 30% of all metastatic tumors. Histologically they usually resemble the parent tumor. They may be single or multiple. Occasionally they have a diffuse spread throughout the leptomeninges rather than being located in the cerebral substance. This type may resemble meningitis both clinically and grossly at the autopsy table. It is readily identified under the microscope.

There appears to have been a marked increase in the incidence of bronchogenic carcinoma in the last twenty-four years. Whether this is a real increase or an increase in the number of diagnosed cases has been argued. There is probably an actual increase, the explanation of which is not clear. The high incidence among the cobalt miners in the Schneeburg mines has been attributed to the inhalation of radioactive substances. There is less evidence for the assumption that carcinogenic coal tar derivatives from tobacco smoke and automobile exhaust have played a part.

Histologically primary lung tumors may be divided into four classes viz. squamous cell carcinoma, adenocarcinoma, alveolar-cell carcinoma and undifferentiated or "oat-cell" carcinoma. Perhaps of more importance from the standpoint of prognosis is the location of the tumor. Those situated at the hilus are usually more slowly growing and are more susceptible to surgical removal either by lobectomy or pneumonectomy. Those arising in the peripheral portions tend to run a more rapid course, metastasize earlier and have an average duration of life of about 7.3 months.

A discussion of bronchogenic carcinoma should include mention of the benign adenomas of the bronchus which may give rise to similar clinical symptoms but which have quite a different histologic picture and offer a much better prognosis. They are more frequently seen in a younger age group and are not as frequent as bronchogenic carcinoma. They can sometimes be completely removed by bronchoscopy but frequently require lobectomy or pneumonectomy. They are slowly growing and metastasize slowly. The metastases are usually limited to the regional nodes, but these tumors have been known to metastasize to the liver and to the vertebral column. There are two main types, one of which histologically resembles the carcinoid of the appendix. The other has some resemblance to the mixed tumor of salivary gland origin. In either type early recognition may lead to a complete cure.

Dr. Robertson: In view of the recent work from the Mayo Clinic by Woolner and McDonald[1] the value of the Papanicolaou smears in the diagnosis of bronchogenic carcinoma should be emphasized. A positive result may be expected in at least eighty per cent of the cases of bronchogenic carcinoma.

1. Woolner, L. B., and McDonald, J. R.: Bronchogenic Carcinoma: Diagnosis by Microscopic Examination of Sputum and Bronchial Secretions. Proceedings of Staff Meetings of Mayo Clinic, 22: No. 18, Sept. 3, 1947.

The President's Page

Back in 1914 when I first started in the practice of Medicine the poor were treated for nothing, the so-called middle class had the *set fees,* but the rich were supposed to pay as much as the *traffic would bear.* We no longer have any Class distinction but, we still have members in the Profession practicing along these lines to the detriment of the Profession at large. Now Mr. General Public becomes confused by the bills that he receives from his doctors. He checks with his friends, and finds they have been paying different prices for similar services, which only adds to his confusion. With no set medical or surgical fees, he begins to kick believing that he too is being soaked. As I see it, the State Medical Society must sooner or later establish a fee schedule for various kinds of Medical and Surgical care. This has been done for the Medical Care of Veterans. To quote from the "Rich Report on Public Relations," "the establishment and publication of fee schedules would largely end the present chaotic system which exposes the entire profession to most damaging criticism."

I would also like to say just a word about Coöperation. We have at this time between fifty and seventy-five of the Doctors in the Association serving on either standing or special committees. They give freely of their time, which means a sacrifice to their own personal gain. Ofttimes, they travel great distances to attend committee meetings. Very seldom do they put in travel expenses. I never realized, until I became the active President of your association, the time and sacrifice that must be put in, on committee work. For example, if you members of the association knew of the work that the Medical Advisory committee, especially its chairman, does in keeping you out of trouble, and keeping your insurance rates down, I am sure it would be a revelation. I want to publicly thank these members for the work that they are doing, and urge the other members to better team work in the Society. If there is to be an opposition, let's not have a whispering campaign, but rather straighten out our differences at our County Meetings, so that our delegates can be instructed how to act at the State Meetings. Remember it is the County Society that should run the show. The State Society is only the deliberation body of the combined County societies. We have many grave economic problems in the Medical Profession in these years to come. We need everyone pulling together in the right direction.

Stephen A. Cobb, M. D.,
President, Maine Medical Association.

Editorial

Causes of Multiple Sclerosis Still Baffle Medical Science

A report on multiple sclerosis released by the National Multiple Sclerosis Society of New York, formed in 1946 for the advancement of research on what has been called "one of the most baffling and devastating diseases in existence," appears in the November 1 issue of *The Journal of the American Medical Association.*

Multiple sclerosis is a widely prevalent chronic disease of the central nervous system. Figures from hospital records provide little information as to its prevalence, since many patients are treated by their own physicians, but in the Eastern Health District of Baltimore between the years 1929 and 1939 there were twice as many multiple sclerosis patients as patients suffering from the after-effects of infantile paralysis.

The disease is characterized by a patchy destruction of the nervous system which occurs during recurrent attacks, usually followed by periods in which improvement is temporarily apparent. Symptoms may be present in almost every part of the body. Most characteristic, according to the report, are inflammation of the optic nerve, blurred vision, blindness limited to one part of the visual field, or weakness or numbness of one arm or leg. Also common are involuntary movements of the eyeball, tremors in the arms or hands, disturbed speech, bladder troubles and general weakness.

"Multiple sclerosis usually begins between the ages of 20 and 40 but is not excluded by an onset before or after these limits," the report states. "The symptoms are often precipitated by infection or by emotional tension or pronounced fatigue and sometimes by pregnancy, and, if so, the diagnosis is rendered more probable."

"There is no agreement among neurologists in regard to the cause of multiple sclerosis; hence, no specific treatment directed at its cause is generally accepted," the report continues. "Possibly the formation or growth of lesions might be prevented by avoiding precipitating factors or counteracting the disease process; possibly mildly damaged nerve elements might be restored by some alteration in nutrition or circulation, and certainly some long-standing symptoms may be alleviated, for example, by relaxation exercises and retraining, which obviously have no beneficial effect on the disease itself. . . .

"The physician can best serve the patient as a wise counselor who helps to relieve anxiety, to work out ways of overcoming physical handicaps and to develop positive interests which make the situation more tolerable. Since new symptoms often appear in a setting of anxiety and tension, a relief of these anxieties may help to prevent further progress of this disease."

Circumstances which may precipitate attacks should also be avoided, the report states. These are acute infections, particularly the common respiratory infections; a cold, damp climate; pregnancy; fatigue; poor nutrition; emotional disturbance; chilling, and, apparently, even trifling injuries.

Muscle re-education by means of special exercises to restore function through the development of substitute motor pathways in the central nervous system has apparently had excellent results in some cases, the report observes. Curare and neostigmine have been used in chronic cases exhibiting abnormally great muscular tension. Other drugs have occasionally appeared to give symptomatic relief, among them amphetamine, "dexedrine," " benadryl" and "pyribenzamine." Vitamins do not appear to have any specific effect on the course of the disease in well nourished patients, but may help others.

Treatment by antibiotic substances, the use of various vaccines and fever therapy—all aimed at combating possible specific infections—have largely been abandoned, the authors go on to say. The practice of sympathectomy (the cutting of the nerves which produce involuntary constriction of the blood vessels, in order to increase blood supply to the parts affected by the disease) seems to have been abandoned, too.

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County Society Notes

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Wednesday, October 15, 1947, at 6.30 P. M.

Clement S. Dwyer, M. D., of Bangor, spoke to the Society on "Modern Anesthesia."

J. H. Crowe, M. D.,
Secretary.

Oxford

The annual meeting of the Oxford County Medical Society was held at the Bethel Inn, Bethel, Wednesday, October 1, 1947. The meeting was called to order by the President, Dr. Walter G. Dixon.

Dr. Linwood Rowe of Rumford, and Dr. Thomas Nangle of West Paris, were elected to membership.

The following Officers were elected for the ensuing year:

President, Dr. Willard H. Boynton, Bethel.

Vice President, Dr. Roland L. McCormack, Norway.

Secretary-Treasurer, Dr. Dexter E. Elsemore, Dixfield.

Councilor, Dr. R. E. Hubbard, Waterford (3 years).

Delegates to the Maine Medical Association: Dr. Lester Adams, Greenwood Mountain (1 year); Dr. Delbert M. Stewart, South Paris (2 years). Alternates: Dr. Henry M. Howard, Rumford (1 year); Dr. William T. Rowe, Rumford (2 years).

Dr. Ralph A. Goodwin of Auburn, Councilor for this District, spoke, stressing the need of more public relations activity. Mr. W. Mayo Payson of Portland, Executive Secretary of the State Association, spoke on the same subject and outlined the tentative plans of the Maine Medical Association in this regard.

At the Scientific Session a panel discussion on "The Diagnosis and Treatment of Accessible Cancer" was presented by: Dr. Joseph E. Porter, Portland; Dr. James M. Parker, Portland; Dr. Theodore C. Bramhall, Portland; Dr. Isaac M. Webber, Portland.

Mr. Herbert E. Locke, Association Counsel, then spoke on various phases of legal medicine.

Dexter E. Elsemore, M. D.,
Secretary.

Penobscot

A meeting of the Penobscot County Medical Association was held Tuesday, October 21, 1947, at the Bangor House, Bangor, with dinner at 6.00 P. M.

Dr. Gilbert Horrax, Neuro-Surgeon, Lahey Clinic, Boston, spoke on "Head Injuries."

There were 61 members and 6 guests present.

J. E. Smith, M. D.,
Secretary.

Somerset

The annual meeting of the Somerset County Medical Society was held October 14, 1947.

Dr. Harland G. Turner of Norridgewock, and Dr.

Edgar J. Smith of Fairfield, were elected to membership.

The following Officers were elected for the ensuing year:

President, Dr. George E. Sullivan, Bingham.

Vice President, Dr. Maurice S. Philbrick, Skowhegan.

Secretary-Treasurer, Dr. H. Carl Amrein, Madison.

Board of Censors: Drs. W. S. Milliken, W. S. Stinchfield, and H. E. Marston.

Program Committee: Drs. H. E. Reed, D. F. Larkin, and H. C. Amrein.

Delegate to the Maine Medical Association: Dr. George E. Young, Skowhegan. Alternate, Dr. Walter S. Stinchfield, Skowhegan.

MAURICE E. LORD, M. D.,
Secretary.

New Members

Oxford

Linwood Rowe, M. D., Rumford.

Thomas Nangle, M. D., West Paris.

Penobscot

Hugh A. Smith, M. D., Bangor.

Somerset

Harland G. Turner, M. D., Norridgewock.

Edgar J. Smith, M. D., Fairfield.

News and Notices

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(Franklin County)

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(Sagadahoc County)

Bowdoinham: Population 915. Contact Mr. Avery Fides, Sagadahoc Fertilizer Company, Bowdoinham, Maine.

(York County)

West Buxton and Surrounding Towns.

For information write to Mr. Parker Byron, West Buxton, Maine.

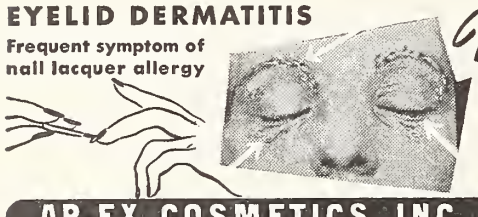
American Urological Association Offers Annual Award

"Urology Award—The American Urological Association offers an annual award of $1,000.00 (first prize of $500.00; second prize, $300.00; and third prize, $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

"The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, Massachusetts, May 17-20, 1948."

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before March 1, 1948.

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Proceedings

NINETY - THIRD ANNUAL SESSION

Maine Medical Association

YORK HARBOR, MAINE

June 22, 23, 24, 1947

SECOND MEETING OF THE HOUSE OF DELEGATES, JUNE 23, 1947

The Second Meeting of the House of Delegates convened at the Marshall House, York Harbor, Maine, on June 23, 1947, with Dr. Stephen A. Cobb, the President-Elect, presiding.

CHAIRMAN COBB: First, we will have the roll call.

(Dr. Frederick R. Carter, Secretary, then read the roll call, and declared a quorum present.)

CHAIRMAN COBB: Gentlemen, I wish you would carry back to your county societies that the delegates you elect to attend this House meeting, if they do not plan to attend, they should not accept the nomination. It really should be serious business. So I wish you would carry that back to your societies, so that next year at least we can have a bigger attendance at our House of Delegates' meeting.

We will now listen to the report of the Nominating Committee, by Dr. Vickers.

DR. MARTYN A. VICKERS, Bangor: The Nominating Committee has appointed Dr. Francis A. Winchenbach, of Bath, to be the Chairman of the Scientific Committee. The new member of the Committee is Dr. Carl E. Richards, and he has been appointed for four years.

(Dr. Vickers then read the report of the Nominating Committee which was published in the July, 1947, issue of the JOURNAL, page 178.

CHAIRMAN COBB: You have heard the report of your Nominating Committee. What is your pleasure?

DR. EBBETT: I move that the Secretary cast one vote for the list of nominations, as read.

This motion was duly seconded and was carried.

CHAIRMAN COBB: You have elected the members of the Standing Committees as read, and I declare them duly elected.

The next business on the agenda is the report of the Cancer Committee by Dr. Gottlieb. He is not here, but he has sent his report in to us, and I will ask our Secretary to read it.

Secretary Carter then read the following report of the Cancer Committee, as submitted by Dr. Gottlieb: *Gentlemen:*

Following is a report of the Cancer Committee for the year ending June 22, 1947:

1. Surveys of the various cancer clinics throughout the state shows active and expanding clinics in the various hospitals throughout the state. An additional clinic was approved at the Rumford Community Hospital during the year.

2. Representatives of the Maine Cancer Society, the Maine Medical Association and the Maine Hospital Association met with the Governor and council on October 19, 1946, to discuss the problem of housing or hospitalizing patients requiring long hospitalization or terminal care. This meeting was attended by Dr. William A. Holt, Dr. Forrest B. Ames, Dr. Julius Gottlieb, and Dr. Stephen Brown. The following resolution was presented, entitled *Proposals for the Care of Patients, Citizens of the State of Maine, Afflicted with Malignant Diseases and Other Selected Diseases.*

Whereas, both national and state and communal statistical data indicate a continual increase in the number of patients suffering from malignant diseases, and whereas, in the State of Maine specifically the vital statistics show a death census of 1400 for the year 1945 and an indication that these numbers are continually increasing, and whereas, the cause of death by cancer represents one in eight of the total deaths throughout the state, representing the second largest cause of death, and whereas, the average longevity of cancer patients is approximately four years, the number of cancer patients requiring care in the State of Maine annually is approximately four times the number of deaths giving a figure of approximately 5000 cancer patients annually, and whereas, there are not sufficient and not adequate facilities for the care of these patients and particularly those patients who are in indigent states and those in terminal state, it is recommended that an institution or institutions be provided by the State of Maine for the care of such patients, and that such institution or institutions may also be rendered available for services to other selected needy patients requiring long term or terminal care.

Whereas, statistical data clearly indicate the gradual decrease of patients suffering from tuberculosis in the State of Maine, and whereas, proof of this is demonstrable that a large number of beds are vacant in the tubercula sanitoria in the State of Maine, it is recommended that these vacant beds shall be so converted that they may become suitable for the receiving of cancer patients and other chosen cases for care, particularly for the indigent, chronic and incurable cases.

It is further recommended that arrangements be made with existing hospitals for the proper staffing of the sanitoria for expert professional care in addition to the proper full-time staffing at the sanitoria. It is the opinion of the committee that at least one physician will be required for the minimal care of fifty patients assisted by one nurse per twenty-five patients. The committee is also of the opinion that laboratory facilities shall be made available either at the institution or by arrangements with existing institutions for radiation and X-ray therapies as well as for the more intricate laboratory studies that may be required.

The committee offers the opinion that with the creation of such services at the various sanitoria a basis will be laid for further development in the creation of a cancer institute as soon as possible which will serve as an institute for concentrated and advanced studies

in the diagnosis, treatment and prevention of cancer through the development of research facilities and as a center for the description of knowledge pertaining to cancer both to the lay public and the medical profession.

The committee is also of the opinion that such an institution as well as the sanitoria rendered available will serve as a stimulus to philanthropic citizens of Maine to contribute of time and means towards the development of institutions for the care of such sick to the highest possible standards.

It is finally recommended that the problem of creation of such an institution or institutions shall be presented to the proper state agencies for the study of costs to implement the recommendations offered, and to present to the proper budget agencies such data and figures as may be required, and that these proposals be presented by the proper authorities for legislative action.

It is hoped that during the next two years preceding the next meeting of the Legislators active support and participation of the various agencies interested will be forthcoming.

Chairman Cobb: You have heard the report of your Cancer Committee. Do I hear any discussion? If not, I will declare it approved as read.

Next is the report of the Amy W. Pinkham Fund Committee, by Dr. Foster.

Dr. Thomas A. Foster, Portland: Mr. President, before I report on the Amy W. Pinkham proceedings, I will say a few words about the Amy W. Pinkham Fund. For the information of those who have not been in the House of Delegates, Amy W. Pinkham left the sum of $20,000 to the State of Maine for mal-nourished and tuberculous children. The provisions of the will requested that the money be given to some organization which was established to carry out public health service. The Cumberland County Probate Court elected to make the Maine Public Health Association the agency to have the income from those funds. They added the provision that none of the money should be spent without the approval or recommendation of a Committee named by the President of the Maine Medical Association. The fund has been in the keeping of the National Bank of Commerce, and during the years it has been there, it has accumulated $2,050.00.

The Committee have never received any proposals for using this fund. The Committee have felt that it should be conservative in the use of the fund, because the fund might be easily dissipated if they engaged in some non-productive policy.

Recently, it has been proposed to the Committee that some of the money be used to furnish the salary of a teacher at the Hebron Sanitarium, where some tuberculous children are treated. The Department of Education, up to this date, have not promised to put in the budget a sufficient salary to pay the teacher for the ensuing year.

Dr. Adams has proposed to the Committee that some of the income from the fund be utilized for that purpose.

This has been given consideration by the members of the Committee.

It has been proposed, furthermore, that some of the moneys from this fund be used to pay a differential between unpasteurized milk and pasteurized milk in

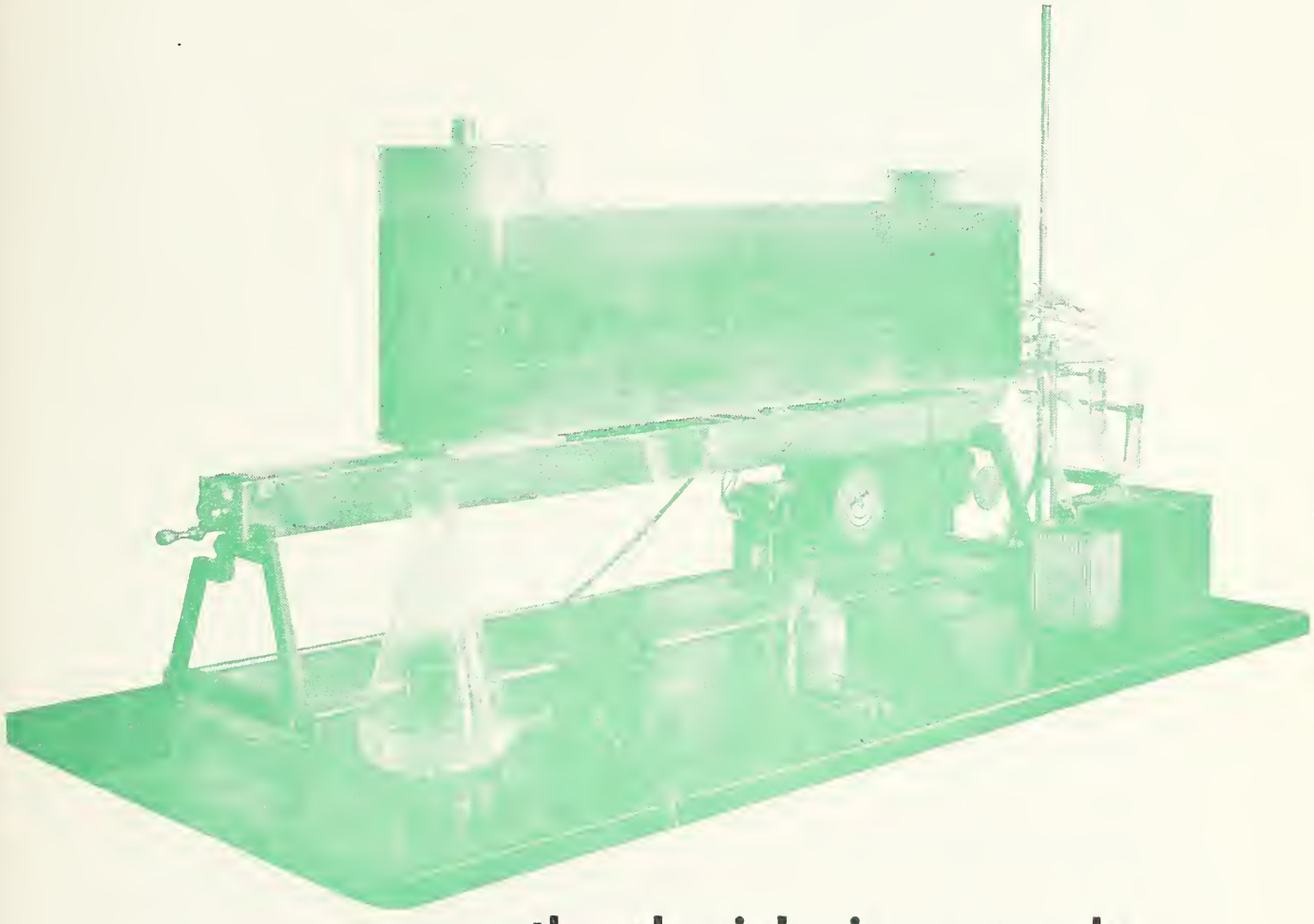
Continued on page 280

HOSPITAL STAFF MEETINGS

Open to the Profession

CITY	HOSPITAL	DATE
Augusta	Augusta General Hospital	1st Wednesday
Bangor	Eastern Maine General	2nd Tuesday
Bath	Bath Memorial Hospital	1st Tuesday
Belfast	Waldo County	2nd Friday
Biddeford	Webber Hospital	2nd Thursday
Boothbay Harbor	St. Andrew's Hospital	4th Tuesday
Caribou	Cary Memorial	1st Wednesday
Damariscotta	Miles Memorial	1st Thursday
Farmington	Franklin County Memorial	2nd Monday
Greenville	Charles Dean Hospital	2nd Wednesday
Lewiston	Central Maine General St. Mary's General	1st Monday 2nd Monday
Portland	Maine Eye and Ear Infirmary Maine General Mercy	1st Wednesday 2nd Friday 3rd Thursday
Presque Isle	Presque Isle General	1st and 3rd Tuesdays
Rockland	Knox County General	1st Monday
Rumford	Rumford Community	4th Wednesday
Sanford	Goodall Memorial	2nd Monday
Waterville	Sisters Thayer	2nd Tuesday Every Thursday

The above list was compiled from a questionnaire sent out by the Maine Hospital Association. Additions or corrections will be made on notification to the Secretary, Maine Hospital Association, Thayer Hospital, Waterville.



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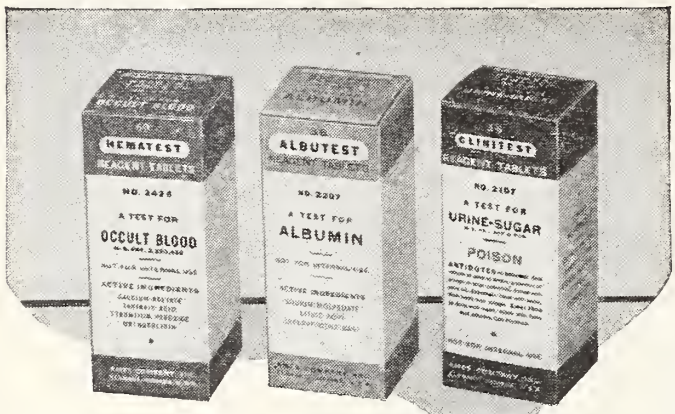
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Proceedings—Continued from page 278

school lunch programs; if there were a differential, the income from this fund would be used to pay the extra cent or two, rather than have the children use the unpasteurized milk.

It has been further proposed to educate the dairy people to the value of pasteurizing milk. No policy has been established for doing that, so that at the present time, the Committee has under consideration these three proposals.

At the last meeting, the Committee were not prepared to make a decision as to which way to spend the fund; but, the Committee wants me to assure you that, left to their responsibility, they are going to be careful about using the funds, and they will be careful to entertain any other proposal for the proper use of the income from this fund.

CHAIRMAN COBB: You have heard the report of Dr. Foster. Is there any discussion? If not, I declare the report approved as read.

Next, is the report of the Reference Committee. It was a fine Committee. I understand they had nothing referred to them, so that they may be discharged.

The next item on the agenda is the election of a Councilor from the Third District.

DR. WARREN E. KERSHNER, Bath: I think the representatives from the various counties have agreed to elect Dr. Jameson, the present incumbent.

DR. GEORGE L. PRATT, Farmington: I move that Dr. Jameson be elected as Councilor of the Third District.

This motion was duly seconded, and was carried.

CHAIRMAN COBB: Next is the election of the Councilor from the Fourth District, Kennebec, Somerset and Waldo Counties.

SECRETARY CARTER: Mr. President, as a member of the Kennebec County Medical Association, I nominate Dr. Foster C. Small of Belfast.

This motion was duly seconded by Dr. Hardy and was carried.

CHAIRMAN COBB: Next is the election of a Councilor from the Sixth District, Aroostook, Penobscot, and Piscataquis to fill Dr. Ames' unexpired term.

DR. CLYDE I. SWETT, Island Falls: I should like to nominate Edward L. Herlihy as Councilor from the Sixth District.

This motion was duly seconded and was carried.

CHAIRMAN COBB: The next item of business is that of unfinished business.

DR. G. E. C. LOGAN, Portland: I should like to ask if changes in the by-laws come under new business?

CHAIRMAN COBB: Chapter 13, Section 1 of the by-laws may be amended at any annual session by a majority vote of the Delegates present at that session. If a proposed amendment has been properly submitted to the House of Delegates, and has lain on the table for one day, the by-laws may be amended.

DR. LOGAN: Inasmuch as we have a session in November, why could not that be held over until November.

DR. FOSTER: I call to your attention that it says "annual meeting" and I think that means the annual meeting. I don't like to discourage you, but the meeting in December or November would not be an annual meeting. Of course, it is up to the Chair to rule on it.

DR. LOGAN: Then it is time to change that, if we are going to have a semi-annual meeting.

CHAIRMAN COBB: If you wish to change any of the by-laws, they will have to lay over until the next annual session.

(To be concluded in the December issue.)

Editorial—Continued from page 274

Other forms of treatment are still in an experimental stage, the report concludes. Accumulating evidence suggests obstruction of the blood vessels as one of the causes of multiple sclerosis. A drug called "dicumarol" keeps the blood from clotting, but has not yet definitely proved its value in treating the disease. Drugs which increase blood supply to the central nervous system seem to give transient beneficial results, but may or may not be effective as a means of long term treatment. In regard to treatment with histamine, the most powerful agent for increasing this blood supply, the Mayo Clinic reports: "Since we began this work in 1942, we have given over 55,000 intravenous histamine injections without any untoward effects." The society, however, does not believe that even this form of therapy can be adequately evaluated until more time has elapsed.

Christmas Seals



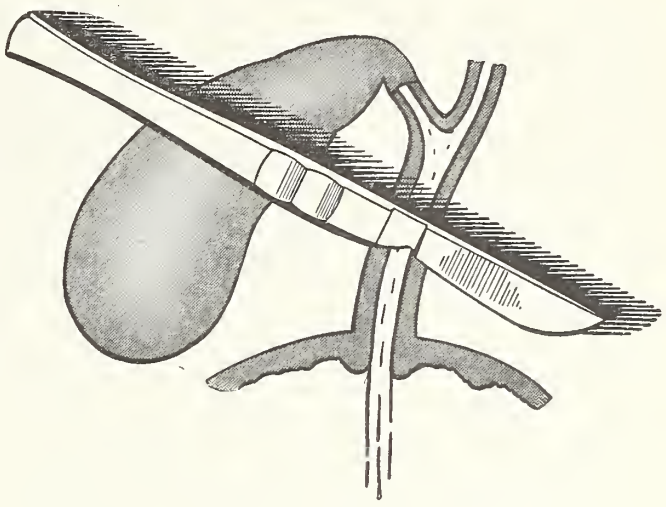
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On Monday, November 24, the 41st Annual Sale of Tuberculosis Seals will go out by mail to the citizens of Maine. Each envelope will carry 200 Seals and a short letter explaining the ways in which the money will be spent, the proceeds of which will be distributed among eighteen Tuberculosis Associations within the state and the Maine Public Health Association. The program of these Associations is one of coöperation with the official agencies both on the local and state level.

Of the money raised through the campaign, only five cents of each dollar goes to support the work of the National Tuberculosis Association. Ninety cents is spent within the state for Case Finding, Health Education, and Rehabilitation of the Tuberculous.

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The Journal
of the
Maine Medical Association

Volume Thirty-eight Portland, Maine, December, 1947 No. 12

*Surgical Diseases of the Gall Bladder and Diagnosis**

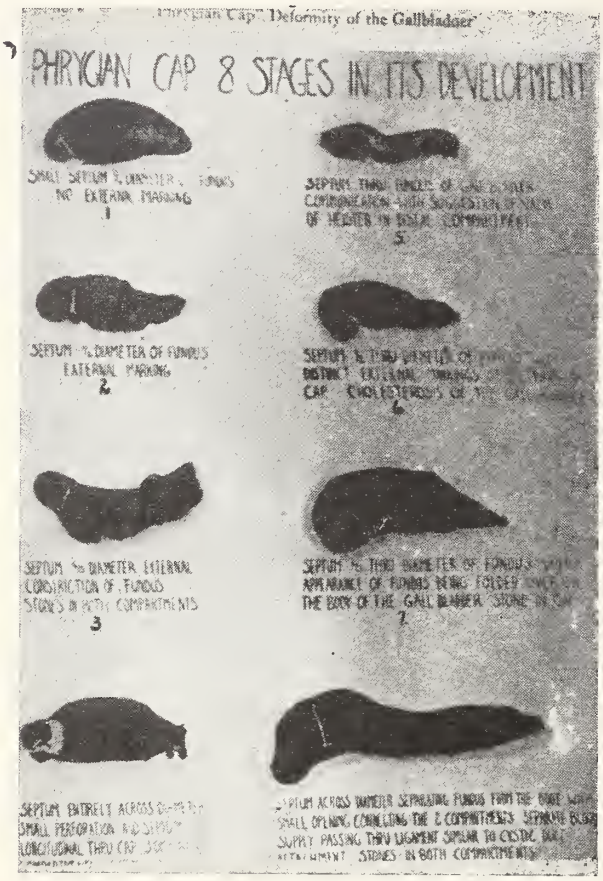
Waldo A. Clapp, M. D., Lewiston, Maine

It seems timely in presenting a discussion of diseases of the gall bladder to mention a convenient classification of surgical diseases, the methods of ascertaining the diagnosis, and a discussion of the frequent diseases encountered in the differential diagnosis. Because it would be impossible to discuss each phase in detail in the allotted 15 minutes, I have decided to lay special stress upon a rather frequent congenital anomaly and upon the incidence of carcinomas of the gall bladder and the coincidence with cholelithiasis.

When one considers the diseases of any organ he first thinks of the congenital anomalies, and the gall bladder because of its embryological development, may be congenitally absent, double, intra-hepatic, or present a congenital cleft which is called a "Phrygian Cap." This anomaly is considered not because of its surgical importance in diagnosis and differential diagnosis, but because of its incidence and its presence is frequently confused with the diagnosis of pericholecystic or cholecysto-duodenal adhesions which are believed to produce traction upon the gall bladder pulling it toward the duodenum, thereby causing the roentgological picture simulating the Phrygian Cap.

Embryologically, the gall bladder arises as an outgrowth from a diverticulum, which, in turn, arises from the duodenum. Finally, the gall bladder is formed by the fusion of a terminal vesicle and the fundus of the gall bladder. This terminal vesicle usually fuses completely with the gall bladder and constitutes its distal extremity. Occasionally, however, there is a separation in the form of a cleft at the line of the fusion whereby the vescile forms a pouch at the fundus similar to a stocking-leg cap. The slide shows stages in the development of this fusion. It may be noted that an incomplete fusion would leave a small stoma between the terminal vesicle and the gall bladder causing stasis in the cap. With stasis, stones are not uncommonly found in the Cap alone. Sweet from Cornell and Myer & Carter from N. Y. Post-Graduate Hospital, report an incidence of 6% and 4% respectively in routine specimens of 100 cholecystectomies on either calculus or non-calculus cholecystectomies and because of the typical X-ray findings, the diagnosis should be made pre-operatively more frequently. It

* Presented at the 93rd Annual Session of the Maine Medical Association at York Harbor, Maine, June, 1947.



Stages in Development.



Phrygian Cap Deformity.

should not, however, play any part in the indications or contra-indications for cholecystectomy.

Dixon and Lichtman found 50 cases of congenital absence of the gall bladder reported since 1900 and added 10 of their cases observed at the Mayo Clinic. Twenty-six of the 60 cases studied were found at autopsy, the remaining 34 cases were found at operation and 6 of these were subsequently confirmed at necropsy. The average age of the patients was 46.7 years, 36 were females and 24 were males. Symptoms consistent with cholecystic diseases were present in 35 cases and jaundice was present in 29. In 15 cases cholecystography failed to produce visualization of a gall bladder. Gall stones were found in the hepatic ducts in 16 cases. This group presents a small number of congenitally absent gall bladders, and as competent surgeons can easily overlook an abnormally placed gall bladder, failure to find it during laporotomy is less convincing than is the discovery of this anomaly at necropsy.

If a T tube is inserted in the common bile duct and a choledochogram made at the time of operation, the possibility of an intra-hepatic gall bladder will be eliminated. The possibility that the gall bladder had been removed at a previous operation without the patient's knowledge, or that there is a very small gall bladder as a result of repeated inflammatory episodes, should always be considered before one makes a diagnosis of congenital absence of the gall bladder.

Classification of Surgical Diseases

A. Congenital Anomalies
 1. Congenital Absence
 2. "Phrygian Cap"

B. Acute Cholecystitis
C. Sub-acute Cholecystitis
D. Chronic Cholecystitis

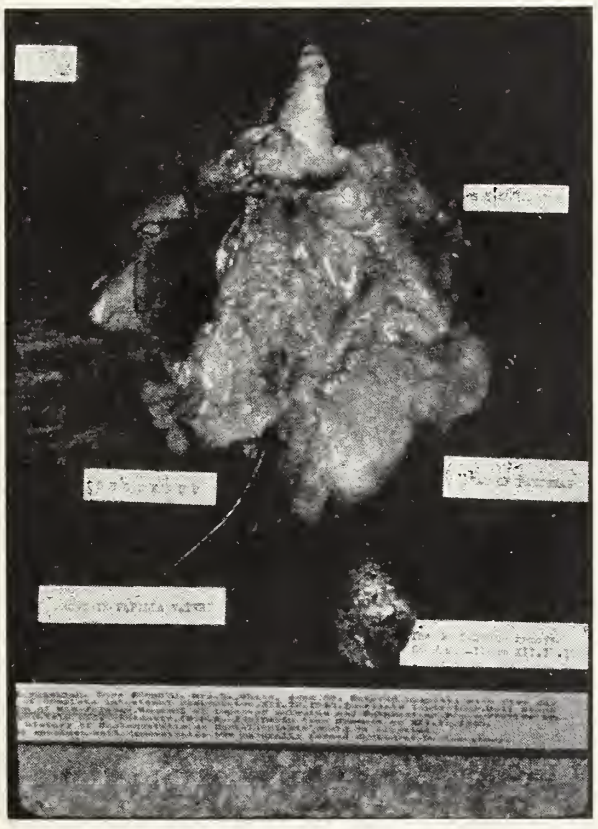
Inflammation of the gall bladder has been divided into three stages—acute, sub-acute and chronic. The gall bladder may be infected through the blood stream, probably the commoner route, through the biliary tree itself (ascending infection) or through the lymphatics. The frequent finding of a large inflamed lymph node (the sentinel node) lends weight to the latter method. The organisms most frequently encountered are B. Coli, micro cocci and typhoid bacilli.

In acute cholecystitis, the wall becomes thickened, browny and edematous. Hemorrhage is a very prominent feature. There may be small patches of fibrin on the surface and gall stones are usually present. One seldom sees it without finding them. If the process progresses, the wall may undergo thrombosis and necrosis followed by perforation. This acutely inflamed organ may cause rapidly developing peritonitis without actually having perforated. They may perforate into the peritoneal cavity, into a hol-



Acute Cholecystitis Cholelithiasis.

low viscus such as the colon or duodenum, or into the liver substance.



Autopsy specimen showing fistula between Gall bladder and duodenum. Stone caused small bowel obstruction.

In sub-acute cholecystitis the serosal surface shows little change. There is little enlargement of the organ and there is neither darkening or fibrosis of the wall. Stones may or may not be present. The interior of the organ is usually a rich orange brown with bright red areas mottling it. In about ½ the cases cholesterosis or strawberry gall bladder is present. The histo-



Strawberry Gall Bladder.

logical picture, however, reveals a fairly extensive infiltration with the eosinophylls, lymphocytes, plasma cells and polys. If cholesterosis exists, cholesterol crystals will be found in the vacuoles of the mucosa.

Chronic cholecystitis is by far the commonest of the inflammatory lesions found at operation. Grossly there is thickening of the wall, the serosa is whitish, the gall bladder may be contracted or dilated if there is a stone impacted in the neck of the organ. On opening the gall bladder one often finds the mucosa absent and a mere fibrous sac left. Occasionally there will be ulcers and less commonly one finds polypoid hypertrophy of the mucosa.

Benign tumors of the gall bladder are uncommon but when they do occur, polyps arising



Chronic Cholecystitis.

Classification cont'd.

E. Tumors
 1. Polyps
 2. Adenocarcinoma
 3. Epidermoid carcinoma

F. Cholelithiasis
 1. Cholesterol
 2. Pigment
 3. Mixed

from the mucosa resemble those of the intestinal tract both grossly and microscopically. From these or from the glands of Luschka, carcinomas may develop of which there are two main types—adenomo carcinoma and epidermoid carcinoma. Adenomo carcinoma are the least common and usually arise in the neck of the gland and grow in the lumen in a polypoid fashion or by infiltrating the walls causing fibrosis. Epidermoid carcinomas are interesting to the pathologist because it was in the gall bladder that metaplasia from glandular to epidermoid types of epithelium was first noted. These lesions are rapidly growing and show typical intercellular bridges. The importance of discussing primary carcinomas of the gall bladder is to stress first its incidence and, secondly, in a large majority of cases it develops as a relatively late sequella to a long standing chronic cholecystitis and cholelithiasis. This may be an additional reason for early removal of a calculus gall bladder.

Finney and Johnson reported 11 patients with this disease over a a 10-year period from their private practice. They state that the incidence for gall bladder carcinoma is from ¼%-¾% of all autopsies, or about 5% of all carcinomas disclosed at autopsy. 8-10% of all carcinomas occurred in the female as compared with the male incidence of 1-4%. The discrepancy is less striking when one realizes that gall stones occur in women over 50 is 14% but only 6% in men. The average age for carcinoma is 60-70 years. 75-80% of all carcinomas of the gall bladder found at autopsy have co-existing cholelithiasis. Since statistically 4-5% of all calculus gall bladders may be associated with malignancy of the organ, when one considers the mortality rate from cholecystectomy as being about 2% and the expectancy of malignancy of from 4-5%, early cholecystectomy for chronic cholelithiasis is justified. The diagnosis is difficult to make pre-operatively as the symptoms are no different from other types of gall bladder diseases. The diagnosis is made usually at the time of operation as indicated by the coexisting cholelithiasis. Too frequently, however, the lesion is inoperable at this time.

A convenient classification of gall stones is: Pigment, Cholesterol and Mixed. They usually occur multiple and are usually facetted. Pure cholesterol stones are likewise uncommon. They are whitish in color and have a mulberry appearance and frequently occur as a solitary stone. However, the most common type of stone is the Mixed having both pigment and cholesterol in a laminated fashion. There have been many theories as to the etiology of stones — the most important are — metabolic, stasis, and infection. Carter, Green and Twiss concluded that probably no single theory was sufficient to explain the etiology and that the combination of the three factors was contributory. In their group, infection was not necessary to the formation of stones and there was presumptive evidence that in many cases infection preceded stones in the gall bladder.

Symptomatology

1. Epigastric or RUQ Pain
2. Nausea and Vomiting
3. Loss of Weight
4. Intolerance to Fats
5. Jaundice

Blalock has analyzed the symptoms of 888 cases of diseases of the biliary tract exclusive of neoplasm but including stones in the common duct and found the symptoms to be in the order of their frequency—epigastric or RUQ pain, 96%, nausea and vomiting—73-76%, loss of weight—66%, intolerance to fats—59% and jaundice—55%. His incidence of jaundice is unusually high and other authors state the incidence is from 10-12%. His higher incidence of jaundice is explained by the fact that he included cases of common duct stones in his series. Amplification of these symptoms is not necessary as you are all familiar with the typical gall bladder colic which radiates to the angle of the scapula on the right and not infrequently to the right shoulder.

The most important physical findings are tenderness in the RUQ or tenderness elicited upon deep inspiration while palpating the RUQ (Murphy's sign) and a palpable tumor mass in the RUQ which is either a distended gall bladder or omentum wrapped around an acutely inflamed gall bladder. A routine rectal examination will disclose occasionally the presence of an acholic stool.

The diagnosis of gall bladder disease is made upon first, an accurate history, a complete physical examination, duodenal drainage with microscopic examination of the "B" bile for pus, cholesterol and calcium bilirubinate crystals, and blood count for leukocytosis.

The 4 diseases most frequently encountered which must be distinguished from gall bladder disease are as follows:

1. Kidney pathology which must be eliminated by a routine urine analysis by the presence of white cells in the urine. Uretero-pelvic obstruction with hydronephrosis, pyelitis or peri-nephritic abscess can easily simulate the signs of cholecystitis.

2. Peptic ulcer causes symptoms which are similar to those of biliary tract diseases in the nature of pain, nausea and vomiting with similar radiation and distribution of the pain. The physical signs may be indistinguishable and can be ruled out only by an X-ray examination of the stomach and duodenum.

3. Acute pancreatitis simulates gall bladder disease and it is not infrequently associated with biliary tract obstruction or infection. In this condition the patient usually shows the typical picture of shock, ashen gray pallor, a fast, thready pulse, low blood pressure and peripheral vaso-dilitation. Its identification is made by serum amylase or urinary diastase determinations.

4. Coronary thrombosis may give symptoms referrable to the mid-epigastrium, nausea and vomiting, or pain referred to the back. Its presence can be ruled out only by electro-cardiographic tracing. When there is doubt as to which of the two conditions is present, gall bladder disease or coronary thrombosis, it is much better to wait for an electro-cardiographic tracing than to operate on a patient with acute coronary thrombosis.

Other conditions which may be confused with gall bladder disease are acute appendicitis, diaphragmatic pleurisy with or without pneumonia of the right lower lobe, omental cysts, gastric crisis, herpes zoster, colitis or malignancy in the right colon. By keeping these entities in mind, one will more frequently make an accurate diagnosis of gall bladder disease.

Differential Diagnosis

1. Kidney Pathology
2. Peptic Ulcer
3. Pancreatitis
4. Coronary Thrombosis

*American Medicine in Transition**

An Address by Edward F. Stegen, Associate Administrator, National Physicians Committee

Society is so necessary to man that God has given him a constitution, faculties, and talents that render him very proper for the state. The faculty of speech enables us to convey our thoughts with facility and readiness, and would be of no manner of use out of society. The same may be said with regard to our propensity to imitation and of that surprising mechanism which renders all the passions and impressions of the soul so easy to be communicated. For example, it is sufficient that a man appears to be moved in order to move and soften others. If a person accosts us with joy painted on his countenance, he excites in us the like sentiment of joy. The tears of a stranger affect us even before we know the cause, and the cries of a man related to us only by the common tie of humanity make us fly to his succor by a mechanical movement previous to all deliberation.

Further than that, we say that nature has thought proper to distribute differently her talents among men by giving to some an aptitude to prove certain things, which to others is impossible, while the latter have received in their turn an industry denied to the former. Now, if the natural wants of men render them dependent on one another, the diversity of talents which qualifies them for mutual aid connects and unites them. These are merely so many evident signs of man's being designed for society. However, the infinite worth of the individual is such a tower in the scale of human values that he has rights even against the state. That is a moral absolute which has nothing to do with his relative worth, his economic or social potentials—it is spiritual and derives from the Infinity which created man as the only moral and reasoning being on earth. These rights are God given—they are the natural law and no state can usurp them.

In our time we have seen a retreat of the spirit. We have seen humanity lose much. We have witnessed a return of barbarism. We have seen the golden thread which binds man to God come perilously near breaking under the strain of an evil weight—the weight of moral disintegration. The ascending curve of man's progress has temporarily turned sharply downward. Fear and moral confusion are the factors which have bent this heaven-bound curve toward the gaping hell of defeatism.

In every period of moral stress the individual loses. His identity as the 'image of God" is taken from him. His spirit is shackled with laws, his mind is fenced in by dictum and directive, and his body survives only because it has the vitality to bear the heavy knapsack of prohibitions which the state has laid upon it.

Throughout history the state has, and probably always will, attempted to gain more power and to centralize and concentrate the controls over its citizens. When the state has had such an ascendancy of power, the exercise of that power becomes an end in itself. Moral restraints are erased. Expediency, defined in the terms of a collectivist ideology, becomes the modus operandi of government. Truth and falsehood are used interchangeably to deceive. Promises are made to be broken. Charters are written to be repudiated. Negotiations between nations are the cloak for treacherous assault.

In America our recently developed defeatist attitude toward the great moral imperatives is a reflection of weakness in the struggle for freedom. Democracy is based upon a moral absolute. Once that absolute is compromised into relativity, it disappears entirely. That strong movements toward this kind of defeatism are in the minds and hearts of American men and women today is evidenced by the new terms in which our national aims are described, the new and often charming names that have been given to the objectives of the social state. In return for our souls we are to receive benefits, care, security, freedom from want, freedom from fear, freedom from all of the hazards of life, parities, subsidies, surplus marketing, bonuses, grants, indemnities, support pay-

* Presented at the 93rd Annual Session of the Maine Medical Association at York Harbor, Maine, June, 1947.

ments, and with the lavishness of a true spendthrift the state will crown the whole abundance of its gifts with freedom of speech and freedom of worship. To appeal from such a bountiful shower of good marks one as an ingrate, a reactionary, and a little farther down this trail of collectivism your name changes to revolutionist, anarchist, or traitor. And should you be so bold as to inquire from whence comes the power, the funds, the authority, the license, and the rules by which the state will perform its miracles of grace and substance, you are marked in some circles as a bloodless capitalist inspired only by your own greed and impelled in the inanity of your questioning by a so-called old-fashioned notion that "all men are created equal; that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

One of the first consequences from the organic nature of the state is the fallacy and absurdity of radical reform. It is both impractical and undesirable because it is unnatural and contrary to the nature of the state and to the nature of man.

Conservatism has been defined as prudence founded on true principles. If we favor conservative action, we favor it insofar as conservatism is true. If the state is truly an organism, composed of a multiplicity of highly organized parts, if it resembles the human body in the organization, as it does in many respects, then it is more foolish and inhuman for a beginner who has only good will to recommend him, to tinker with such a living mechanism, than it is for a farmer with a kitchen knife to explore the delicate organism of the human body. "Just rashly to hack that aged parent to pieces, put him into the kettle of magicians in hopes that by their poisonous weeds and wild incantations they may regenerate the paternal constitution and renovate their father's life," is the way Edmund Burke puts it. Medicine has made great strides, but can hardly repair even some of the most unimportant tissues. What are we to think of the statesman who attempts to rebuild the entire mechanism of the state—and that in a few months? The idea is preposterous. One of the main reasons why we should regard radical reform with horror is the fact that radical change constitutes a condemnation of the human race. Radical reform admits a contempt for the judgment of mankind, speaks of "ancestor worship" and considers that men have waited for this latter day to find truth and wisdom. From such sweeping condemnation of our ancestors and the cumulative wisdom of humanity we must be the great defenders.

There are other reasons why radical or sweeping change in government is impractical and undesirable (besides the fact that it is foreign to all our principles). The first reason is that there is a vast difference between any plan of radical reform and its realization in the body politic. It is a well-known fact that man's habits and sentiments lag far behind his ideas. Politics must be adjusted not to human reasonings, but to human nature. The customs of the people are not as readily changed as some politicians and reformers would imagine. There is an important principle of government that law must ordinarily follow customs and not to attempt to form them, except in cases of rare necessity. The second reason is the fact that you must necessarily affect the whole body politic. Experience shows that the results of such reforms are often contrary to the expectations of those who advocate them. We must realize that interference with a social system is one thing and the control of the results of that interference is quite another.

It is a weakness of all reformers to think that their control of the change which they advocate is in proportion to the hopefulness of their initiative. They do not understand history aright. They do not know that statesmen have often in the past raised tariffs so as to foster home industries and thereby ruined home industries; have artificially raised the price of silver to allow certain nations to purchase more goods, and as a result destroyed the financial credit of those same nations. They do not realize that they may press radical measures for the reform of the state only to find that they have fostered a revolution. It is a commonplace of political experience that political forces seldom observe the limits or follow the forecasts of those who set them in motion. We can all recall cases in which well-meant legislation has failed because it has neither aroused the expected sympathy nor enlisted the expected support, or because it has given unforeseen

offense to some party or has aroused some unexpected passion.

We cannot oppose justly prudent reform, but any student of history must know and realize that civil society is a delicate organism, and as such is particularly liable to injury, and that the laws of men may be all too easily perverted into instruments of ruin and misery for the people.

Today the people of this great country must be stirred and awakened to the danger which is imminent. We have been in the race toward statism for more than a generation, and if our pace is accelerated now, that phenomenon is as much due to a tail wind generated by world events as it is to our present administration in Washington.

What can be done to slow down this accelerated pace is the greatest and gravest problem which each American faces today because in the fast race toward statism lies the kind of moral defeat that may well liquidate the military victories which we have won. In many ways the social science doctors who thrive on the sicknesses of the distressed community or nation during the adjustment period following the war have blinded us to the real considerations and the fundamental questions involved. The collectivist economists and social planners have left no stone unturned to convince us that we, though creatures endowed by God with inalienable rights and abilities, cannot get along without a governmental hypodermic needle, pumping stamina into our veins.

It is too much, perhaps, to hope that the national leadership which gained power out of our depression-born defeatism can change its methodology. It is too much to expect no doubt that politicians who have won the longest periods in office in all our history by the irresponsible use of the hypodermic needle will suddenly change from a counsel of despair to one of dynamics and confidence.

As long as we are dominated by the defeatism which demands the aid of government witch doctors—the constant injection into the veins of our society of hastily-brewed economic, social, and political serums of unknown or questionable potency and inefficiency—we will never stand on our feet as real Americans and carry individually the proper portion of community responsibility which should be ours. As long as we, the people, go to Washington for our every need, as long as we permit the use of that great synthetic "government action" as a substitute for individual responsibility and courageous individual attack upon our problems, we will never free ourselves from the enervating and devastating effects of the trend toward collectivism.

I have endulged your patience thus far without pointedly bringing any close-drawn application to medicine. However, I have taken these liberties because I believe that it is necessary to move back a considerable distance from some things in order to examine them in their true proportions.

Moving up then to a consideration of the relative place of medicine in the fight to preserve for this nation the great traditions of freedom—the defense of the moral imperatives of the American way of life—I propose to show you that the learned profession of medicine through its unity of purpose and with a continuation of consecrated and intelligent leadership can lead America away from the false security of cowardice and upward and onward to new adventures of freedom.

The trend toward regimentation of the medical and allied professions has been marked by the introduction of the five Wagner health bills, with which most of you are familiar.

The most recent legislative proposal for the establishment of a system of compulsory sickness insurance is embodied in the current Senate Bill 1320, introduced by Senators Wagner, Murray, Pepper, Chavez, Taylor and McGrath. The enactment of this bill, which is the most adroit and clever piece of legislative writing that the proponents have ever created, would lay upon the people of the United State in its most vicious form a scheme of punitive taxation and, take away from the medical profession every vestige of the independent practice system. In brief it would do these things:

1. Hire doctors, specialists, dentists, nurses, laboratory technicians, and establish rates of pay.

2. Establish fee schedules for physicians' and dentists' services.

3. Fix the qualifications for specialists.

4. Determine the number of individuals for whom any doctor or dentist may provide service.

5. Determine what hospitals or clinics may provide service for patients and under what conditions.

6. Provide for all wage earners and their dependents and for all self-employed persons and their dependents — doctor, dentist, home nursing, and laboratory care and hospitalization.

It is estimated that the cost would be more than four billion dollars annually. Based on experience in other countries, it would take at least 300,000 lay bureaucrats to administer this system of politically distributed medical care.

Doctors know that an easier method must be provided for paying the costs of unusual or prolonged illness. That is why so many prepayment plans and insurance programs are being developed. Given reasonable time for expansion, these plans and programs will bring adequate relief.

In the United States we have never witnessed a transfer of function from the field of purely individual activity to that of government activity. There has always been an intervening stage, a period in which the problem hangs in suspension and during which public opinion makes up its mind one way or the other. This is the stage in which certain activities are institutionalized. It is generally agreed that the distribution of medical care is now in the period of suspension. Public opinion is fluent on the subject—it will swing to a crystallized position within the next two years, and at this moment it is impossible to predict whether it will swing to state medicine or an institutionalism under the traditional concepts of free enterprise. However, I wish to emphasize by repetition that men and women like you can swing public opinion to a positive position which will make it impossible for the collectivists to steal from our people their birthright of freedom, not only in the field of medical care, but more importantly will start this nation on the road back to spiritual, social, economic, and political good health.

Perhaps some of you find it difficult to believe that American medicine must add to its task of caring for the ill and stricken, the challenging responsibility of social and economic leadership in the distribution of medical care and services, but this is "the call" of our time.

It is generally believed that the distribution of medical care as distinguished from medical care itself will be institutionalized. This fact stands out in the results of every survey of public opinion which has been made on the subject. The American people are demanding some provisions against the hazards of illness and disability. Particularly, a majority of our citizens want economic protection against catastrophic and extended illness. This public demand means that we no longer have a choice in the distribution of medical care between individual activity and governmental activity. That choice has vanished. Your choice, the choice which the American people will be in the process of making during the next few years, is a choice between the two types of institutional responsibility, private and public. If medicine will rise to the challenge of leadership, thoughtful and courageous men and women all over America will stand with you against the intrusion of the killing hand of bureaucracy into the field of medical care, and not all the cascades of beautiful words about new social goals, bold social engineering, or the tongue-in-cheek promises of security from the cradle to the grave will prevail against us.

Fortunately for the American people the medical profession has a constructive and specific program that in all respects protects the interests and the dignity of the individual, insures the creation and extension of voluntary plans of health insurance. That program is expressed in a recent statement of policy of the National Physicians Committee. Its significant phases are:

1. To encourage the medical profession to active participation in the development of plans and the more general use of existing facilities to provide for easy payment of insurance against unusual or prolonged illness;

2. To educate the people to the importance, nature, and value of prepayment facilities (within the framework of principles approved by the medical profession) now available for meeting the costs of unusual illness;

3. To investigate conditions relating to and inform industry concerning the principles un-

derlying sound participation with employees in prepayment plans for meeting the cost of unusual or prolonged illness and hospitalization;

4. To inform private insurance underwriters of the opportunity that is being offered through coöperation in nation-wide efforts to provide group insurance policies for those needing or desiring insurance against the hazards of unusual illness;

5. Encourage the more generous use of government funds administered at state and local levels to insure effective medical care for the indigent.

6. Encourage contributors and friends to a greater degree of participation in the efforts of the National Physicians Committee in this constructive program.

The participation of physicians throughout the length and breadth of America in this constructive program is a growing force in our national life. In a recent address Dr. Morris Fishbein had this to say about the program which the profession has determined to follow and the place of the National Physicians Committee in that program:

"The National Physicians Committee has been most effective of all of the organizations striving to mold public and legislative opinion in the field of medical care. Its efforts have been repeatedly endorsed by the House of Delegates of the American Medical Association. This agency has used syndicated newspaper publicity and editorial opinion, newspaper advertising, pamphlets, radio, direct-by-mail solicitation, education, and every other technic of public relations in its work. * * * Through this group also, physicians are being educated as to the details of the proposed legislation and they will be encouraged to make direct contact with legislators from their own states to make certain that the legislators are fully informed. The budget approximates several hundreds of thousands of dollars, and the funds are, as nearly as I can determine, efficiently and economically used. The medical profession owes a great debt of gratitude to the distinguished physicians who serve as the directing board of the National Physicians Committee and to the staff who carry out so effectively the policies that this board establishes."

Today, America's greatest danger lies in the possibility that it may fail to meet the challenge of protecting those fundamental concepts which have been the guiding stars of progress in the past, and which today, tomorrow, and forever are the celestial lights by which man must chart his course toward freedom. The cooperative leadership of men and women in the professions in the struggle for human progress, for the protection of the dignity and sanctity of the individual may very well be the benchmark from which we, as a nation, will measure a new era of freedom, a greater exercise of our rights of citizenship and a renewed faith in the moral absolutes of democracy.

During the past 50 years tuberculosis has been declining more rapidly in childhood and adolescence than at any other age. In fact, tuberculosis has become primarily a disease of middle-aged and old people. In Massachusetts the reaction rate to the tuberculin test in school children dropped 50 per cent between 1925 and 1940, and the amount of pulmonary tuberculosis found by mass examination fell proportionately. In Tennessee, with a high tuberculosis death rate, the state department of health reports five cases per 1,000 among high school students, compared with two per 1,000 found in Massachusetts. Alton S. Pope, M. D., *NTA Bull.*, Nov., 1946.

Tuberculosis constitutes a humanitarian problem of great magnitude. The most recent comprehensive review, that of the United States Census Bureau in 1938, includes mortality figures for only thirty-two nations. The rates varied from 40 per 100,000 to 260. For a large part of the world's population, tuberculosis deaths are unrecognized, uncounted, or both. It is impossible, therefore, to make more than the roughest estimate of the toll which the disease exacts. It is safe to say, however, that there occur each year in the world more than three million deaths from all forms of tuberculosis and that the total probably exceeds five million. James A. Doull, M. D., *NTA Trans.*, 1946.

Clinico-Pathological Exercise

Case Presented at the Maine General Hospital, Portland, Maine

Edited by Joseph E. Porter, M. D., Portland

This is the case of a 45-year-old white housewife who was admitted to this hospital with the complaints of diarrhea, epigastric pain, and vomiting, of 11 days' duration.

Present Illness: The patient was apparently perfectly well until 11 days prior to admission, when she noted the sudden onset of diarrhea, which was followed by the onset of epigastric pain, nausea, and vomiting. Over the next few days these complaints became progressively worse, and then some began to gradually subside. At admission the vomiting had ceased; the diarrhea was lessening, but the epigastric pain remained severe and constant. During the course of her present illness there had been anorexia, and there was a history of passing stools described as tarry. There was no history of cough, hemoptysis, or loss of weight. No history of jaundice was obtained, and no urinary symptoms.

Past History: Patient had pneumonia in childhood; no other serious illnesses; no operations; no history of jaundice or acholic stools. Appetite had been excellent up until the present illness, although the patient habitually avoided fatty and fried foods because they did not seem to agree with her.

Physical Examination on Admission: Well-developed, well-nourished obese white female, appearing to be acutely ill. Temperature 99.8°; pulse 100; respirations 22; B.P. 70/52. Eyes: Pupils equal, round, regular, reacted to light and accommodation. Ears and nose essentially negative. Throat: Mucous membranes moist; tongue coated; pharynx not unusual. Neck: No rigidity; no adenopathy. Lungs: Expansion adequate and symmetrical; resonant throughout. A few scattered inconstant rales at right base. Heart not enlarged. Normal regular sinus rhythm. Heart sounds slightly muffled; Grade I systolic murmur heard at apex, which did not radiate. Abdomen: Obese; no muscle spasm; generalized tenderness over the entire addomen, most pronounced in the epigastrium; no masses felt; liver, spleen, kidneys not felt. G.U.: No costovertebral angle tenderness. Vaginal and rectal examinations negative. Extremities: One plus pitting edema of both feet and ankles. Reflexes: Knee jerks not elicited; otherwise reflexes were equal and physiological.

Laboratory Work on Admission: Hemoglobin 89%; WBC. 17,500; differential: Neutrophils 84%; eosinophils 3%; lymphocytes 12%; monocytes 1%. RBC. and platelets were not unusual in smears. Urinalysis: Appearance cloudy; straw color; reaction alkaline; S.G. 1.020; albumin 5 mg.; no sugar, acetone, diacetic acid, casts, RBC., WBC., or epithelial elements noted. Kahn and Hinton negative. On the 3rd hospital day the B.U.N. was reported as 17 mg.%.

The patient was treated symptomatically. For the first few days while in the hospital she continued to complain of nausea, but vomiting was not recorded. There was persistent epigastric pain and several watery stools per day. On the 5th hospital day a chest X-ray revealed some increased density at the left base, as compared with the right, also the right diaphragm was noted to be considerably higher than normal. On the 9th hospital day a repeat chest film showed general increase in the hilar regions, and the right diaphragm was still high, and, in fact, appeared somewhat higher than in the previous film. On the 10th hospital day a progress note indicated that the patient's abdominal complaints were still present, and that now she had become dull and stuporous. Her temperature was fluctuating between 99 and 101.2°. The blood clot culture was reported as negative.

On the 14th hospital day the blood count was again repeated and reported as follows: WBC. 23,100; differential: neutrophils 51.5%; eosinophils 38.5%; lymphocytes 10%.

Platelets appeared normal in smears. Many stippled cells were seen. On the following day the patient's condition had markedly deteriorated. There was pronounced cyanosis; there was dullness and absent breath sounds over the right base. Heart sounds were of fair quality, but the pulse was only barely perceptible. During the evening of the 15th hospital day the patient became comatose; blood pressure could not be elicited, and she expired early on the 16th hospital day. During the patient's hospital course her temperature ranged between 99 and 101.6°; her pulse between 98 and 120; and her respirations between 25 and 40. The B.P. never went higher than 98/60. During the first 8 hospital days the patient had between 1 and 4 watery to soft bowel movements per day, but after that time an enema was required daily. Occult blood was reported in the stool on the 13th hospital day. Parasites were never found in the stool.

Discussion

Dr. Benjamin Zolov: Essentially we have an acutely ill, obese, middled-aged female, who was perfectly well previously, according to the history, with the exception of a little disturbance from fried and fatty foods. On admission she was acutely ill, in shock, B.P. 70/52, complaining of severe epigastric pain rather than other G.I. symptoms. The blood findings were quite significant. On admission the patient showed a leukocytosis, with 84% neutrophils and 3% eosinophils, and then on the 14th day she showed a white count of 23,000, with 50% neutrophils and 38% eosinophils. Ruling out any of the acute G.I. disturbances, such as a bacillary group, which apparently was done from some of the cultures taken, in a middle-aged patient who apparently had no food poisoning of any kind, and enjoyed previous good health, there are several significant features in this case which require observation. She appeared in shock-like condition from admission to death. What appeared to be either mild inflammatory or early congestive changes in the lungs continued during the entire hospital stay. The changes found in the blood differential — eosinophilia of 38% — is pretty high, and one you won't find in the ordinary run of cases. It says nothing of any previous allergies. One finds an increased eosinophil count quite significant in certain parasitic infections, Hodgkins disease, sometimes in tumors of the ovary, metal poisonings, tuberculosis, malaria and peri-arteritis nodosa. Sometimes in rare skin diseases like pemphigus and dermatitis herpetiformis an eosinophilia may be present. The patient constantly complained of epigastric distress more than diarrhea which caused 1 to 4 loose watery bowel movements during the day. The laboratory report on one occasion reported the color of the stool, though no other evidence of color was noted. She had a history of tarry or bloody stools before admission. I would attribute this to the acute G.I. distress, which was severe prior to admission. At no time was there any marked spasm of the abdomen. Apparently the medical department felt there was no question here of any surgery. I do not see any surgical consultations. She must have been under medical care the entire time. Stippled cells are mentioned, which are usually seen in some of the metal poisonings, and in marked anemias or some of the leukemia pictures. To me, in placing a lot of emphasis on the blood picture, I would put considerable stress on the parasitic type of infection causing this patient's present symptoms and finally her death. I would consider acute trichinosis for the following reasons: The upper G.I. tract can become involved by invasion of the larvae into the mucous membrane of the duodenum and jejunum, causing marked nausea and vomiting, with invasion of the mesenteric lymph nodes later. During the first ten days there may be no particular change in the blood picture, but after the second week, during the invasive phase, there is a marked change toward eosinophilia, and death may result in a period of four weeks in severe cases. Lung complications, like secondary bronchopneumonia with some pleural effusion, may be a terminal affair. I would consider acute fulminating trichinosis as the cause of her illness. As a secondary diagnosis, I think in a patient of this age, despite the fact that in the history she had no history of epigastric or G.I. disturbances, and one in which the blood picture is peculiar to certain conditions, one would have to consider a G.I. malignancy, which may have gone along quietly for months, then suddenly the G.I. malignancy could slowly perforate, giving her gas in the abdomen, which would

give her the epigastric pain, with some right diaphragm elevation and subsequent termination of her illness in death. The second diagnosis is of course rather unlikely, because of the history of the patient. I would consider acute trichinosis as the diagnosis which is difficult to rule out in this particular patient. I would like to know if any agglutination tests were done.

Dr. Franklin F. Ferguson: The Widal was postive for B. Typhosus up to a dilution of 1-80. Blood culture was negative.

Dr. Zolov's Diagnosis:

1. Trichinosis, acute.
2. Gastrointestinal malignancy.
3. Periarteritis nodosa.

Dr. Philip Thompson, Jr.: How do you explain the edema of the legs?

Dr. Zolov: There is infiltration of the lymph glands in these cases, which may be enough to produce some secondary edema. Also, in acute trichinosis there may be some thrombi involving the intestinal tract, and secondarily the lower extremities. We must remember that this patient was a very obese woman, and that she had vomiting and nausea, which may have been a factor in the edema.

Dr. James Parker: Were stools examined for parasites?

Dr. Ferguson: Yes, but none were found. Stool and urine cultures were also negative.

Dr. Parker: Were there any findings other than those which were in the history?

Dr. Ferguson: No.

Dr. Parker: I would like to suggest a diagnosis of amebiasis, with amebic liver abscess.

Dr. Charles Glassmire: I would like to suggest eosinophilic leukemia.

Anatomical Diagnosis:

Acute trichinosis.

Dr. Ferguson: The gross anatomical findings in this case were as follows:

1. Early pneumonia, most marked in the right lower lobe.

2. Splenomegaly, mild (200 gms.), hepatomegaly, moderate (1850 gms.).

The diagnosis was made on the basis of the microscopic findings. The trichinae were demonstrated in large numbers in the diaphragm and in the psoas, sternocleidomastoid, and pectoralis muscles. The heart showed interstitial collections of eosinophils, with some monocytes and lymphocytes, as well as some congestion and edema. The lungs showed areas of congestion and edema, with red blood cells and occasional neutrophils in the alveolar spaces. The liver showed marked fatty infiltration, with some fatty degeneration of cells around the central veins. The kidneys showed cloudy swelling of the tubules. The sections of the meninges showed edema, hyperemeia, and inflammatory infiltration. The trichinae were not found except in the sections of muscles. This case is one of a group which occurred in 1935. Dr. Hawkes may be able to give us some details of other cases.

Dr. Richard Hawkes: These cases were all traced to an Italian who raised two hogs which had been fed on garbage. He kept one himself and sold one. Most of this hog was made up into pork sausage which was passed out among a number of Italian families in this area. Dr. Dr. Drake and I hunted up all the people we could discover who had had any of this material, and of this group there were 56 who showed eosinophilia or positive skin tests for trichinosis, or who were sick with the disease. There were two deaths, this case and one other.

Dr. Eugene Drake: I believe the diagnosis was made in this case before she died.

Dr. Philip Thompson, Jr.: When these cases die of pneumonia, do the trichinae pass through the lungs?

Dr. Ferguson: The trichinae are believed to pass through the lungs, but we were unable to find the trichinae there in this case. They were not found in the brain or heart either, although it seems likely that they had been there, especially in view of the eosinophilic myocarditis.

Dr. Drake: Dr. Frothingham has reported cases in which the trichinae were found in the heart.

Dr. Ferguson: It is easier to make the clinical diagnosis now, because of the extensive use of the skin test. I think Dr. Zolov is to be congratulated in emphasizing the time relationship in the development of the eosinophilia in his analysis of this case.

The President's Page

Our Fall Clinical Session at Lewiston was one of the best. A lot of credit is due the Androscoggin Society, the Session Committee, and the participants in the Program. It meant a lot of time and work. The Meeting of the House of Delegates for the second time in the year was well worth while. There occurred a lot of lively discussion, and the session extended into the social hour. However, the delegates seemed willing to stay. We had a real democratic meeting, and everyone had something to say. The meeting adjourned in harmony. The Council meeting, was also worth while. Some of the members of the House of Delegates asked for the publication of the proceedings of the Council. These can always be found if you will read the JOURNAL. The proceedings of the House of Delegates, and the Council cannot be printed verbatim. For the good of the Society, parts must be censored by your Editorial Board, and left out.

Most important of all to a functioning State, County, or Local Medical Society is good professional relations. Fundamental to good professional relations must be a good feeling and understanding among the individuals composing the Medical Society.

The seven characteristics that mark a good Medical Society are:

1. Enterprise
2. Progress
3. Friendship
4. Harmony
5. Vision
6. Leadership
7. Courage

Lack of interest, cliques, and discord will ruin any organization.

We need, a change in our licensure laws, prepayment insurance, physicians in many of our rural communities, and a Public Relations program.

To get all these the Professional Relations in our Society must be 100%.

Here is wishing all the members of the Society, and theirs, a Happy Holiday Season, with Health and Prosperity in the year to come.

STEPHEN A. COBB, M. D.,
President, Maine Medical Association.

Editorials

The Fall Clinical Session

The Fall Clinical Session of the Maine Medical Association, sponsored by the Androscoggin County Medical Society, was held in Lewiston, November 9 and 10, with an attendance of more than 145 members and guests.

A Social Hour at the Hotel DeWitt on Sunday, November 9 from 7.00 to 8.00 P. M., official opening of the session, lent an air of informality to the occasion.

Dr. Ashley W. Oughterson, Clinical Professor of Surgery at Yale University and Chairman of the Joint Commission for investigating the effect of the Atomic Bomb in Japan, guest speaker at the Sunday evening meeting, described medical aspects of the atomic bomb. The effects of radiation from the atomic bomb was clearly shown in the illustrations which accompanied Dr. Oughterson's lecture.

The clinics on Monday, November 10, from 9.00 A. M. to 5.00 P. M., at the Central Maine General Hospital and St. Mary's General Hospital, were ably conducted and covered many phases of medicine and surgery.

Dwight E. Harkins, M. D., of the Boston City Hospital, was guest speaker at the closing meeting of the session held Monday evening at the Mansion House, Poland Spring.

Dr. Harkins described the technique of Cardio-Vascular surgery, and the removal of foreign bodies from the heart region. His talk, which was extremely interesting, was illustrated by documentary motion pictures taken of operations performed in the European war theatre.

The Committee on Arrangements, under the chairmanship of Dr. Wiliam V. Cox, are to be commended for the excellence of the program, and for the hospitality shown those fortunate enough to be present.

The Council, House of Delegates, and Editorial Board Meet During Clinical Session

The Council and House of Delegates of the Maine Medical Association, and the newly appointed Editorial Board of THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION, met Sunday afternoon, November 9th, at the Central Maine General Hospital, Lewiston, preceding the Clinical Session.

The Council heard the report of Dr. Francis A. Winchenbach, Chairman of the Scientific Committee, relative to the program for the annual meeting to be held at the Poland Spring House, June 20, 21 and 22, 1948. The committee is endeavoring to arrange a program which will be of scientific value to every member, and which will also allow more time for social activities—and those get-togethers which seem to make so many so late to scheduled conferences and scientific sessions. Their tentative plans were approved by the Council and will be enlarged upon in a later issue of the JOURNAL.

Your President, Dr. Stephen A. Cobb, was empowered to appoint a special committee on Rural Health Activities. This committee is to serve until the June, 1948, meeting at which time a permanent committee will be appointed.

Dr. Forrest B. Ames, President-elect of the Association, was appointed delegate to the 1948 annual meeting of the Maine Dental Society.

Dr. Oscar R. Johnson, Chairman of the Social Hygiene Committee, was present and read a letter from the Director of the State Department of Health and Welfare relative to the much discussed Venereal Disease Law. It was voted that the Director of Health and Welfare be invited to attend the next meeting of the Council, and that in the meantime he be in-

formed relative to the discussions which have taken place regarding this law.

EDITORIAL BOARD

Dr. Eugene E. O'Donnell was appointed Chairman, and Dr. Lawrence M. Cutler, Acting Secretary, of the newly appointed Editorial Board at the organization meeting of that group. The Board, which was appointed in accordance with a vote of the Council in session August 17th, consists of the following members: Eugene E. O'Donnell, M. D., Portland, First District; Waldo A. Clapp, M. D., Lewiston, Second District; C. Harold Jameson, M. D., Rockland, Third District; Richard P. Jones, M. D., Belfast, Fourth District; James H. Crowe, M. D., Ellsworth, Fifth District; and Lawrence M. Cutler, M. D., Bangor, Sixth District. Each member of this Board has appointed a member from each County Society in his district to assist him in securing material and papers for publication in the JOURNAL. The Board plans to meet again in January or February at the time of the next meeting of the Council.

HOUSE OF DELEGATES

If attendance is any criteria of the success of holding an interim meeting of the House of Delegates, then the meeting can be declared a success, because 30 of the 35 county delegates were present at this first interim meeting, and participated in lengthy discussions of many matters of interest to the members of the Association. It was the concensus of opinion that many irksome questions had been satisfactorily answered. The minutes of this meeting will be published, in part, in future issues of the JOURNAL. It does not seem feasible that this verbatim discussion be published in its entirety, but it is on file in the office of your State Secretary and is available to any member of the Association at any time.

Committee on Rural Health Appointed by Stephen A. Cobb, M. D., President

The following Committee on Rural Health has been appointed by Dr. Cobb, President of the Maine Medical Association, in accordance with a vote of the Council in session November 9th at Lewiston:

Norman H. Nickerson, M. D., Greenville, Chairman.

Harry Brinkman, M. D., Farmington.

Stanley R. Lenfest, M. D., Waldoboro.

Wallace E. Viles, M. D., Turner.

Storer W. Boone, M. D., Presque Isle.

Harvey C. Bundy, M. D., Milo.

George H. Coombs, M. D., of Waldoboro, Recommended for American Medical Association General Practitioner Award

The House of Delegates of the Maine Medical Association at its interim session, November 9th, at Lewiston, voted unanimously that George H. Coombs, M. D., of Waldoboro, Honorary Member of the Maine Medical Association, be recommended for the Distinguished Service Medal for General Practitioners to be presented by the American Medical Association at its mid-winter meeting to be held in Cleveland, Ohio, in January, 1948.

Hobson's Choice? Not Yet.

Some time ago the Council gave me permission to write for the JOURNAL about matters connected with my job. In the July JOURNAL I did write briefly about proposed national and state legislation for compulsory sickness insurance which results in what you generally refer to as socialized medicine. Since this matter of compulsory insurance is largely the reason for this public relations job I would like, in about three short articles, to discuss with you the proposed Federal legislation, the reasons and arguments given for it, and the suggestions and proposals of the American Medical Association to remove any foundation for these arguments.

I take it for granted that if this remained solely a matter of your choice you would prefer to go on with the private practice of medicine just as you do today and always have done in the past. Leading doctors all over the country, officials of the American Medical Association, officials of your state society, have sound reason to believe that it is no longer a matter of free choice and that some voluntary plans for better distribution of medical care are necessary, or government — state or federal — will step in with a compulsory plan. Indeed, the present battle is being waged on whether socialized medicine, i. e., the Murray Bill, shall be adopted immediately, or whether it may be postponed to see if voluntary plans, including voluntary insurance for prepaid medical care, can be implemented to their fullest extent and thereby remove some of the major arguments for socialized medicine. Your choice, therefore, in the opinion of students of the problem and of officials and leaders in organized medicine, is not whether you shall continue the practice of medicine as you always have or accept voluntary plans; in their opinion, the choice allowed you is whether you will promote and urge voluntary plans, or, lacking them, will have compulsory sickness insurance imposed by federal statute.

The Murray Bill, S. 1320, is the present legislation before Congress to set up a national compulsory sickness insurance plan. Beside Senator Murray, the bill is sponsored by Senators Wagner, Pepper, Chavez, Taylor and McGrath. I still hear many of the doctors refer to it as the Wagner-Murray-Dingell Bill, and, while I don't care what you call it (some of the things couldn't be printed), I want to make sure that when the papers or someone with whom you are talking refer to the Murray Bill, you know that the reference is to the present compulsory insurance proposal, which is a lineal descendant of the deceased (but unlamented) Wagner-Murray-Dingell Bill.

Apparently the arguments of the medical profession against the centralization of the administration under the Wagner-Murray-Dingell Bill were taken to heart by its sponsors because the Murray Bill is filled with sections about decentralization, state administration and local administration. Some person with a turn of mind for figures (and who wasn't too busy) counted the number of times such phrases recur in the language of this bill.

The bill permits administration at the state level by a state agency such as our Bureau of Health. This state agency must, however, submit a plan of operation which complies with certain sections of the bill and also meets with the approval of the National Health Insurance Board. This Board is to consist of five members, two of whom would be doctors; one, the surgeon general, the other an M. D. licensed to practice in a state. The Board seems somewhat restricted by the provision that its functions "shall be administered under the direction and supervision of the Federal Security Administrator."

So, under the decentralized Murray Bill, the top administration is in the Federal Security Administrator, and, under his direction, by the National Health Insurance Board which has the power to make regulations and prescribe standards; and the money comes from the Federal Government. John Marshall didn't have a powerful Federal Government when he said, "The power to tax is the power to destroy." If he had been faced with the present national government he might well have said, "The power to dole out the money is the power to control the work subsidized."

The coverage of persons eligible for benefits under the bill is estimated to be about 85% of

the population. The benefits which they are to receive include medical services, dental services, home nursing services, hospital services, and auxiliary services such as laboratory services, optometrists and chiropodists.

The provisions for financing this enormous proposition are apparently a payroll tax which would undoubtedly be a withholding tax. The experience of all employers with withholding for income tax purposes, when that was instituted, was that the employee figures that all he gets is what he takes home and pay increases were immediately demanded to restore the take-home-pay to its original figure. In other words, the employer eventually paid the withholding.

The withholding tax for 1950-52 would probably be 3½% of payroll (up to $3,600.00 of income) and for 1953-55, 4% of payroll. Self-employed persons would also be taxed, and, of course, be eligible for benefits.

I haven't attempted to give a comprehensive or detailed analysis of the bill. All I want to do at this time is to hit the high spots so that you will have the general picture in mind. Later, as the bill comes to further committee hearings, we shall all see more about it and have more detailed explanation of its contents. For the moment, I am satisfied if I've gotten across the fact that the Murray Bill, S. 1320, is the bill in which you have an intense interest. And, so do all your patients, if they only knew it.

W. Mayo Payson,
Executive Secretary.

Correspondence

American Red Cross
Portland Chapter

97 State Street
Portland, Maine

December 2, 1947.

Maine Medical Association,
142 High Street,
Portland, Maine.

I wish personally to show my appreciation for the splendid coöperation and efficiency the members of the Maine Medical Association have shown me during my association with them in the capacity of Disaster Chairman of Cumberland County.

In the time of the disaster, your organization's assistance proved invaluable to me for the efficient functioning of my group.

I would appreciate it very much if you would fan out to your association my sincere appreciation for the splendid coöperation during this catastrophe.

Sincerely,
E. W. Shedley,
Disaster Committee Chairman,
Portland Red Cross Chapter.

EWS:ed

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Without obligation send me full details concerning your service.

Name
Street
City

Necrologies

William H. Chaffers, M. D., 1887-1947

William H. Chaffers, M. D., 60, eye, ear, nose and throat specialist in Lewiston, Maine, since 1915, died November 29, 1947, an hour after having been admitted to St. Mary's General Hospital suffering from a heart attack.

He was born in Worcester, Massachusetts, in 1887, the son of Dr. and Mrs. Joseph Chaffers. He received his medical degree from the University of Montreal, Canada, in 1909, and interned at St. Mary's General Hospital in Lewiston.

Dr. Chaffers was a member of the Androscoggin County Medical Society, the Maine Medical Association, and the American Medical Association.

He was a former member and one time chairman of the Lewiston Board of Education, having served on that municipal board for several years, and at the time of his death was a director of the Manufacturers' National Bank of Lewiston.

He is survived by his widow, the former Bertha Bolduc, four daughters and three sons.

Lindley Dobson, M. D., 1864-1947

Lindley Dobson, M. D., 82, of Presque Isle, Maine, died July 4, 1947.

Dr. Dobson was born in 1864. He was graduated from Bellevue Hospital Medical College, New York, in 1891.

He was a member of the founders group of the American Board of Surgery, a fellow of the American College of Surgeons, a member of the New England Surgical Society and the American Medical Association, and an Honorary Member of the Aroostook County Medical Society and Maine Medical Association. He received a Fifty-Year Medal from the Maine Medical Association at the annual meeting held in 1941.

E. Motley Fuller, M. D., 1880-1947

E. Motley Fuller, M. D., 67, of Bath, Maine, died December 2, 1947.

He was born March 10, 1880, the son of Dr. and Mrs. Edwin M. Fuller. He was graduated from Bowdoin College in 1901, and received his medical degree from Bowdoin Medical College in 1904. He interned at the Maine General Hospital, Portland, Maine, and took a post-graduate course at Kensington Hospital for Women, Philadelphia. He had practiced in Bath since 1906, and was President of the medical staff of Bath Memorial Hospital, and was one of two survivors of the original hospital staff.

He was the second in a three-generation succession of doctors. His father, a native of Portland, practiced in Bath from 1873 to 1913. His son, Edwin M. Fuller, 3rd, began his practice there ten years ago.

Dr. Fuller was a member of the Lincoln-Sagadahoc Medical Society, the Maine Medical Association and the American Medical Association.

Surviving are his widow, Mrs. Marguerite Robert Fuller, the son, and one daughter.

Edward P. Goodrich, M. D., 1874-1947

The death of Dr. Edward P. Goodrich occurred at his home in Winterport on October 27, 1947, after several months of failing health.

He was born in Newburg, Maine, April 3, 1874. He attended the public schools of Newburg and Hampden Academy. He later attended Bowdoin College and received his medical education in Baltimore, graduating from Baltimore Medical College in 1896. He also took courses at Johns Hopkins University and the University of Maryland.

Dr. Goodrich began private practice in Pittsfield, Maine, later moving to Plymouth, Maine, where he also served as Superintendent of Schools. In 1910, he moved to Winterport where he practiced until the time of his death, with the exception of thirteen years, 1920-1933, when he was associated with the State Department of Health, during which time he resided in Lewiston. While serving in this capacity he lectured at Bates College on Public Health. He was a medical examiner for Waldo County, which position he held until the time of his death.

He was prominent in community affairs and fraternal organizations, being an active member of the Masonic Order, Order of Eastern Star, Independent Order of Odd Fellows, Rebekahs, Independent Order of Foresters and the United Commercial Travellers.

Dr. Goodrich always took an active interest in medical affairs and was a member of the American Medical Association, the Maine Medical Association, and a member and past president of the Penobscot County Medical Society. He received a Fifty-Year Medal at the 1940 annual meeting of the Maine Medical Association in 1946.

He is survived by his widow, Dorothy Goodrich, and a stepdaughter.

MARILYN JOHNSON.

Sarah L. Hunter, M. D., 1857-1947

Sarah L. Hunter, M. D., 90, of Machias, Maine, died August 14, 1947.

Dr. Hunter was born in Steuben, Maine, July 4, 1857, the daughter of Dr. and Mrs. S. B. Hunter. She was graduated from Mt. Holyoke College, and received her medical degree from the Women's Medical College of Philadelphia in 1891. She began the practice of medicine in Machias in 1891.

She was an Honorary Member of the Washington County Medical Society and Maine Medical Association, and a member of the American Medical Association. She received a Fifty-Year Medal from the Maine Medical Association at the 1931 annual session at Greenville, Maine, being one of the first twenty-eight members of the Association to be so honored.

COUNTY SOCIETIES

Androscoggin
President, Michael J. Harkins, M. D., Lewiston
Secretary, Glidden L. Brooks, M. D., Lewiston

Aroostook
President, Gerald H. Donahue, M. D., Presque Isle
Secretary, Clyde I. Swett, M. D., Island Falls

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President, Edward A. Greco, M. D., Portland
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Secretary, John Young, M. D., Jonesport

York
President, Oscar W. Perrault, M. D., Biddeford
Secretary, C. W. Kinghorn, M. D., Kittery

County Society Notes

Hancock

A regular meeting of the Hancock County Medical Society was held at the Hancock House, Ellsworth, Maine, Thursday evening, November 13, 1947.

Robert H. Delafield, M. D., of Ellsworth, and Charles H. Knickerbocker, M. D., of Bar Harbor, were elected to membership in the Society.

Hugh A. Smith, M. D., of Bangor, spoke on "Cholecystography." Following presentation of his subject there was a period for general discussion.

J. H. Crowe, M. D.,
Secretary.

New Members

Cumberland

Arnold W. Moore, M. D., Portland, Maine (By transfer from Kennebec County Medical Society).

S. Frank Fox, M. D., Portland, Maine (By transfer from Durham, N. C.).

George Loewenstein, M. D., Chebeague Island, Maine (By transfer from Cook County Medical Society, Chicago).

Hancock

Robert H. Delafield, M. D., Ellsworth, Maine.

Charles H. Knickerbocker, M. D., Bar Harbor Maine.

News and Notes

Have You Received Your American Medical Directory Card?

The Eighteenth Edition of the American Medical Directory is now being prepared for publication.

In November a directory card was mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. If you have not received a card please write at once to the Directory Department, American Medical Association, 535 No. Dearborn Street, Chicago 10, Illinois, for a duplicate card. If you have received your card and haven't filled it out and returned it please do so at once.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations and activities, and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Openings for General Practitioners in Maine

(Franklin County)

Rangeley: Population 1464. Contact Dr. Donald J. Winslow or Dr. John H. Moulton, Rangeley, Maine.

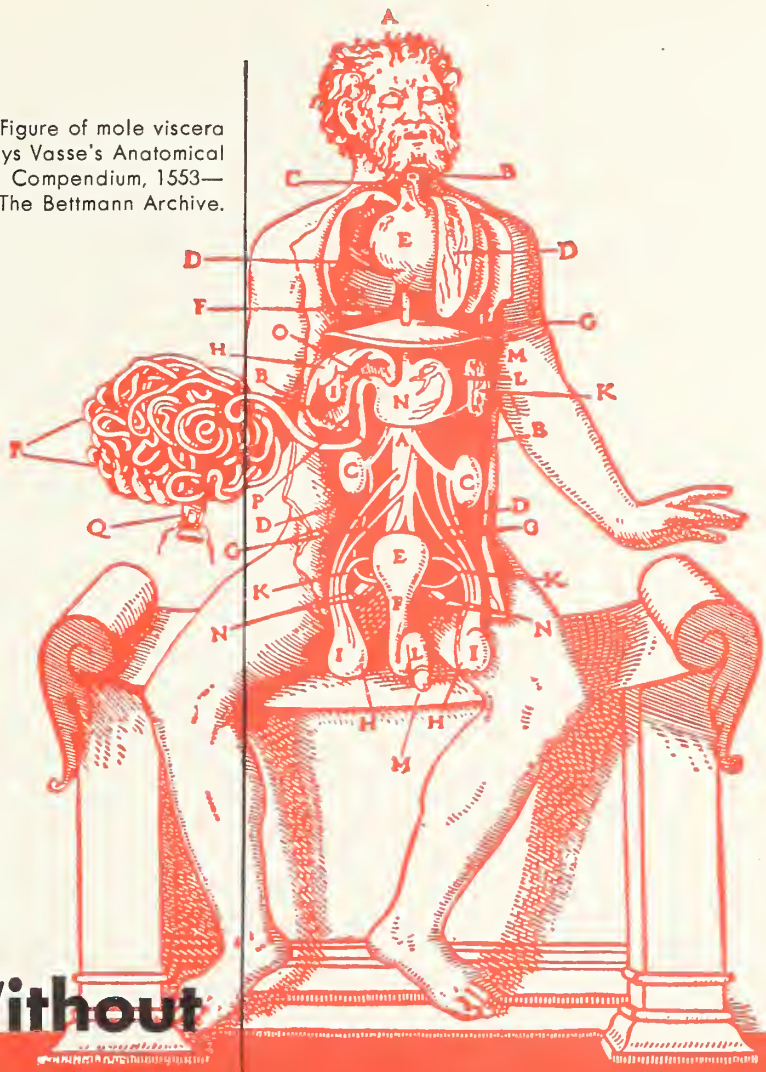
(Sagadahoc County)

Bowdoinham: Population 915. Contact Mr. Avery Fides, Sagadahoc Fertilizer Company, Bowdoinham, Maine.

(York County)

West Buxton and Surrounding Towns.

For information write to Mrs. Frederick H. Davis, West Buxton, Maine.



Anotomy: Figure of mole viscera from Loys Vasse's Anatomical Compendium, 1553—Courtesy, The Bettmann Archive.

Without accurate knowledge...

of human anatomy and physiology, without stethoscope or electrocardiograph, it is small wonder that physicians of the 16th Century were helpless before many of the conditions for which present day medicine possesses efficient treatment.

Present day knowledge of the anatomy and physiology of the heart and respiratory tract has led to the widespread use of

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*Searle Aminophyllin contoins at leost 80% of anhydrous theophylline

Proceedings

NINETY - THIRD ANNUAL SESSION

Maine Medical Association

YORK HARBOR, MAINE

June 22, 23, 24, 1947

SECOND MEETING OF THE HOUSE OF DELEGATES, JUNE 23, 1947

(Continued from the November issue, page 280)

DR. KERSHNER: Mr. Chairman, of course, it is possible, tomorrow, to have another meeting of the House of Delegates if the matter is important enough, and the Delegates could be called together at any time during the session. We are the Legislative Body of the House, and this House can be called together every hour, if necessary. So that if Dr. Logan's suggestion is important enough, you can call a meeting of the House of Delegates tomorrow.

DR. LOGAN: Well, Mr. Chairman, may I say that there are two or three things that I wish to speak about. I think that one is probably handled in the by-laws, although not very clearly.

Now, the delegates are ordinarily elected for two years. They do not get a chance really to understand what is going on in that time, and there has been a great deal of talk about the "Old Guard" ruling things, and I think that should be clarified.

The second thing that I wish to speak about is this. There are thirty-four delegates. In the First District, there are ten, and that is practically one-third; yet, we have one-sixth representation. There certainly should be another district, so we should have two members of the Council, instead of one.

The third thing is that we are spending a lot of money for an Executive Secretary.

I notice that he is appointed by the Council. I think that he should be appointed by the Delegates.

CHAIRMAN COBB: Does anyone else wish to discuss Dr. Logan's ideas?

DR. KERSHNER: It specifically says that any change in the by-laws must be presented as a positive change, and not as a suggestion. If you have any motion to make, as to the change, we can take it.

DR. LOGAN: Would I not be allowed a little discussion beforehand to see whether it is warranted? Maybe I am going off on the wrong foot.

DR. KERSHNER: If you make a motion, you have something to discuss. It should be in writing, too.

CHAIRMAN COBB: It has to be in writing, and brought to the attention of the House of Delegates, and then at least lay over for twenty-four hours.

DR. LOGAN: I think that this is of paramount importance that we get the proper man to represent us in the Legislature, if nothing else.

What happens when a big company wants to get a law passed? They don't have one man. They may have a man who is the head-liner, but they spend money around in the various counties through the key man in each county.

The medical profession has always been against getting down into the mud, and going to the fight for what they want. But, that is not the right idea. Spend your money. Put a little money into the various districts, and, if those men are not coöperating, get your doctors to get after them.

I wish that somebody would make a motion for me, because I am not very good at making motions, or anything of that kind. If Dr. Kershner would do it under my name, I would be pleased to have him do it.

DR. KERSHNER: Any change that is made or any proposal has to be put in writing. I certainly would not do it on the spur of the moment, under any consideration. I hadn't given it any thought. I was trying to formulate how it should be done.

DR. LOGAN: Would I be out of order in asking the Chair to formulate the motion for me.

CHAIRMAN COBB: I am here to carry on the business of the Association.

DR. FOSTER: Mr. Chairman, is it not possible for Dr. Logan to go into the ante-room and formulate his motion? I understand that there is more business to come before the House, and while the House is in session, perhaps Dr. Logan could be permitted the time to step to a writing desk and write out the suggestions that he has in mind, and submit them before this House, then they can lay on the table overnight, and be discussed tomorrow morning and approved or disapproved.

CHARMAN COBB: This should have been brought up yesterday and referred to the Reference Committee.

DR. LOGAN: I am sorry, sir, but I didn't read the by-laws.

CHAIRMAN COBB: Is there anthing else to come up under unfinished business?

DR. SWETT: Yesterday, I spoke about the need for the State Medical Association to continue its endeavor toward prepayment medical care and the State Medical School.

I should like to propose a motion, authorizing the Chairman to appoint a Committee of three, to serve on the State Committee as set up by the Legislature, and also, if you have a strictly Maine Medical Association Committee, as we have had this past year, to continue its research and endeavor along the lines of these two programs, feeling, as I do, that we have started this thing right, and we are getting just under way, and it would be too bad to leave this session without some definite plans for continuing it during the coming year, regardless of the outcome.

Well, that is a double motion, really. I ask that the motion read that the Chair be authorized to appoint a Committee of three to serve on the Committee, as set up by the Legislature, which has been requested by the Legislature.

Also, that we have a committee purely from a standpoint of the Maine Medical Association, appointed to

continue its service during the coming year on the same program.

These motions pertain to the medical school.

I also wish to make a motion that we continue the program on the matter of prepaid medical care.

CHAIRMAN COBB: You have heard Dr. Swett's motion. Is that motion seconded?

.

DR. SWETT: Mr. Chairman, in order to keep the argument from going further, may I amend my motion to read that the Chair be authorized to appoint three members to the State Committee, if and when the Governor asks for these names, and that the Chair be authorized to appoint a purely medical association committee, to continue its research.

This motion was duly seconded and was carried.

CHAIRMAN COBB: Is there anything else under unfinished business?

Is there any new business to come before this House of Delegates?

DR. VICKERS: Mr. Chairman, I have a resolution on the subject on the National Physicians' Committee.

Whereas; The Members of this House of Delegates as well as the physicians throughout Maine are cognizant of the effective work which the National Physicians' Committee for the Extension of Medical Service has performed during the past five years in bringing about better distribution of medical care and a higher level of understanding on the part of the public of the achievements, methods and aims of the medical profession; and,

Whereas; This House of Delegates also recognizes that the maintenance and extension of the program which the National Physicians' Committee has so effectively carried forward requires substantial revenues; therefore

Be It Resolved that the House of Delegates of the Maine Medical Association register approval of the activities of the National Physicians' Committee and recommend to its constituent societies and all individual physicians of Maine that they give voluntary moral and financial support to the National Physicians' Committee.

DR. VICKERS: As you know, we had a representative of the National Physicians' Committee here last evening. It is my feeling that the State Society should do something constructive about working with this particular group. First of all, I should like to have the House of Delegates pass upon the resolution, and then I should like to make a motion regarding the future activities of the National Physicians' Committee.

DR. WINCHENBACH: I move that the resolution be adopted.

This motion was duly seconded by several of the members present.

DR. PLUMMER: Last year, I opposed a resolution of this kind. I haven't changed my mind. I am not in favor of socialized medicine in the least. I am opposed to it.

Perhaps there are some members of our Association who are resigned towards something along the lines of socialized medicine. I don't think it is fair to take any part in this nor in their political actions.

I get a letter every once in a while, saying that there is a great emergency and if I don't send $100 or $25 and I don't know whether they got down to $10 or not, some dire happenings are going to take place to the disadvantage of man and everybody else. I haven't yet replied; not with any contribution anyway.

Anybody who wants to contribute to the fund, that is all right with me. But I prefer that our influence should not be used in that way. I prefer that mine should not be used that way, as a member of the Association. Whatever I do in that respect, I prefer to do by writing to the Senators or the representatives or both. I do think that the Association should go on this way endorsing these matters because while they may be of interest to us, at the same time there may be more or less of a division of opinion as to the advisability of it among the members of the Association.

I trust that the motion will not prevail.

CHAIRMAN COBB: Is there any further discussion?

DR. FOSTER: Mr. Chairman, as a delegate from this State to the American Medical Association House of Delegates, may I say that the question of re-affirmation of the work done by the National Physicians' Committee was discussed in friendly terms, at some length. Both sides of the question were presented before the House of Delegates by a competent speaker. The House, after listening to the debate, re-affirmed their approval of the work which has been done by the National Physicians' Committee, under the aegis of that group.

The House of Delegates believes that the work accomplished by the organization has been extremely helpful in combatting legislation and particularly the new Murray-Dingell Bill, which is a threat to our present way of practicing medicine.

CHAIRMAN COBB: Is there any other discussion?

DR. PLUMMER: I should like to ask Dr. Foster one question. Are the Delegates to the American Medical Association more competent men than we are, barring yourself, of course?

DR. FOSTER: They are men who have given a great deal of thought to the question.

The question arose, after the Rich Report was brought in. Raymond Rich, you will remember, if you have read the *A. M. A. Journal,* suggested that no connection be retained between the National Physicians' Committee and the A. M. A. But, this recommendation of Mr. Rich's was disapproved. His report was based on rumor, without foundation, and aroused a good deal of opposition to that report. After careful consideration by a Committee of men from all over the country, Dr. Scannell from Massachusetts was our nearest representative, they recommended that the House go on record again as approving the work of the National Physicians' Committee.

CHAIRMAN COBB: Is there any further discussion?

(The question was then called for.)

CHAIRMAN COBB: All those who are in favor of the motion will please signify by saying "aye."

There was a chorus of "ayes" and the motion was carried.

DR. VICKERS: Now, I should like to make the motion that as long as this resolution has been accepted, that the President of this Association be empowered to appoint a Committee from the State of Maine, which will work with the National Physicians' Committee.

This motion was duly seconded by Dr. Richards and was carried.

CHAIRMAN COBB: Is there anything else under new business?

DR. ERVIN A. CENTER, Steep Falls: Following out Dr. Logan's remarks a few moments ago, some of the delegates retired to discuss the subject with reference to the Executive Secretary. Inasmuch as there seems to be, among some of the delegates, considerable dissatisfaction with the record of accomplishment as to legislation, yet at the same time, realizing that undoubtedly the Budget has been pretty well set up at the present time by the Council of the Association, and

realizing that good, solid, constructive work is rarely accomplished in a movement without careful study, we beg to present, instead, this resolution:

Be It Resolved: That the Council of the Maine Medical Association be requested to study the qualifications and the record of accomplishment of its Executive Secretary, Mayo Payson, with a view to determining whether or not he is the proper man for this position.

I move the adoption of this resolution.

Dr. Logan: I will second the motion.

Chairman Cobb: Gentlemen, you have heard the motion. Is there any discussion?

(The question was then called for.)

All those who are in favor of the motion will please signify by saying "aye." Those opposed?

There was a chorus of "ayes" with many members not voting, and the motion was carried.

Chairman Cobb: Is there any further new business?

Dr. Plummer: Mr. Chairman. I have a resolution here, a couple of them, which I should like to present, regarding the subject I raised yesterday afternoon.

At the request of Dr. Foster, or rather at his suggestion, I have drawn up the following with regard to the cigarette advertisements in the *Journal of the American Medical Association:*

Whereas, the *Journal of the American Medical Association* is published with a view to the information and education of the individual members and for the promotion of the interests of the profession as a whole and for the improvement of the public health and not primarily as a financial venture, and

Whereas, some of the advertisements appearing therein have no connection with these purposes,

Therefore, Be It Resolved: That it is the sense of the Maine Medical Association, in Annual Session assembled in June, 1947, that advertisements such as liquor, tobacco or other products having no reference to the aforesaid objectives are out of place in our *Journal,* and

Be It Further Resolved, that our representative be directed to bring this matter before the House of Delegates of the national organization, the American Medical Association, and urge the discontinuance of this policy.

Mr. Chairman, I move the adoption of this resolution.

Dr. Foster: I will second the motion.

Chairman Cobb: You have heard the motion of Dr. Plummer. Is there any discussion?

Dr. Plummer: I should like to say this. In looking through the *Journal,* we are primarily interested in things that relate to the profession, at least I am, and it offends my aesthetic sense of the eternal fitness of things to find in there an advertisement for cigarettes; as I stated yesterday, I can't see any reason for advertising cigarettes, liquor, bathing suits, or anything else. It strikes me that if a person has a room in his house that was fixed up and nicely painted and quite expensively fitted up, he would hardly stick up an advertising calendar in the midst of it. It would be an incongruity, and I object to it in that sense.

I do not want to be misunderstood. I do not oppose the use of liquor. But I do oppose some of the cigarettes. I prefer to take my tobacco by other methods, which I might say has three advantages. A chew of tobacco once in a while is less conspicuous, less expensive and with more satisfaction. That is the reason I don't like to see the advertising there; it offends me.

Chairman Cobb: Is there any further discussion? If not, all those who are in favor of the motion will please signify by saying "aye." Those opposed?

There was one "aye" vote and an overwhelming majority of dissenting votes, and the motion was lost.

Dr. Parker: I am sorry to prolong the meeting, but several members here have mentioned the fact that they wondered if it wouldn't be pertinent for the problem of the nursing shortage to be brought up in this meeting for some discussion or reaction on the part of this meeting of the House of Delegates.

Those of us who are concerned with the problem of getting general duty nursing done in the hospitals are being faced with an increasing lack of available nursing material, and an increasing number of private duty nurses who object on various grounds to doing general duty in the hospitals where they are sorely needed.

I don't wish to make any motion; I just wish to bring it up and see if any of the members have any comment to make on it, or any ideas about it.

(There was no action taken relative to this question which was discussed at some length by Drs. Swett, Logan, Call, Center, F. T. Hill, Ebbett and Stuart. Dr. Hill stated that the Maine Hospital Association had discussed the question at their annual meeting and that "a committee from the State Hospital Association is investigating the problem and the question of the practical nurse." He further stated that "the Maine Health Council, of which this Association is a member, and on which I represent you at present, has taken this matter under consideration, and a newspaper campaign will be shortly inaugurated throughout the State, trying to interest these young women to come into the training schools." Complete discussion of this subject is on file in the Portland office.)

Dr. Foster: Mr. President, yesterday afternoon, the subject of the Journal was discussed. We have as a delegate here from Connecticut, Dr. Stanley B. Weld, who has been Editor of the *Connecticut Medical Journal* for eleven years, and he has put that *Journal* into fifth place in the state journals all over the country.

Now, if you would like some information regarding a better Journal, and if you would like to take a few minutes to hear him, I know that you will be well rewarded.

Chairman Cobb: I am sure we would be glad to hear from Dr. Weld.

Dr. Stanley Weld: Mr. Chairman and Gentlemen; it is a pleasure to be here. We, who are practicing physicians must be united and working as a team because of many things, among them being the inroads that have taken place from our central government office in Washington.

I feel very strongly that one of the cementing factors in the medical society is a good publication, and, for that reason, we have tried to make our publication in Connecticut a good one.

Your Journal is much older than ours. I have very little to offer you probably, because your experiences go back many more years than mine. But, I must tell you that it is a full-time responsibility in a part-time job, and that whoever takes over the publishing of a state medical journal has got to live with it day and night, and be willing to put his time into it from morning 'til night, Sunday to Saturday night, year in and year out, as long as he keeps that job.

There are several factors in a journal that perhaps I could run over hastily. I am just going to take two or three minutes.

The first problem is the securing of scientific papers.

Our state is the only one that has made a student membership in the Society. By so doing, we have been able to contact or establish a contact with medi-

cal students; not only those who are in Yale Medical School in Connecticut, but those who have gone out from Connecticut to other medical schools. I bring this in merely as a suggestion, because these boys in the new resident program are producing scientific material that you might well get hold of, if they knew you were interested in them and in their material, in order to publish it in your JOURNAL.

We have difficulty at times in getting material, because of the shortage of speakers, shortage of papers and the like.

Now, a second thought along that line is that if you can stimulate your own members to produce papers, to sit down and put their thoughts and the results of their work on paper, it will bring forth more results. We are finding that to be true in our own State.

There is another part of the Journal which is extremely important. It must be carried out with a great deal of conscientiousness and perseverance, and that is the editorial section of the Journal.

Whoever writes the editorials must get around the country. He must know the issues that are taking place, not only in his own State, which is very important, but also in Washington and across the whole continent.

In order to keep the medical profession informed, the one who writes the editorials must write on pertinent subjects and do a good job of it; that goes without saying.

We have established departments in our *Journal.* I don't know whether you would be interested in that or not. But, I think that a pattern to go by is that every active committee in the state association should have a page or pages in the *State Journal.*

For instance, we have a Committee on the Care of the Veterans. There is, in our *Journal,* a section on "Medicine and the Veteran" and in that section goes all that pertains to the medical care of the veteran in Connecticut, and whatever is of interest in the United States as a whole.

We also have a Committee on Industrial Health, and in the section marked "Industrial Health" appears the work that is being done by that committee in the state. They may not have a section in every issue; but, frequently they do. And, over the heading of that section appears the name of each member of the committee. So it goes on down through the line of committees.

We have a Committee on Public Affairs, and they have a section in the *Journal,* and they are very active.

I can wind up, perhaps, by saying that one of the most difficult problems that some of the editors have found has been the inability to get County news into the Journal. I think that perhaps we have solved that in Connecticut better than in a good many states. I am thinking of New York now, which gets all the county news out of the daily press, which I think is terrible. We have, in each county in Connecticut a news reporter, a news editor, and we make him a sort of an ancillary member of the Editorial Board. We invite him to our dinners, and pat him on the back a little bit, so that that fellow is doing in each county an increasingly better job. We get news, now, about the men, their appointments in city affairs, their prominence in this, that or the other thing, and whatever seems to be of interest to other members in the profession in our state.

Just a word, finally, about the book reviews. I have found here at the Maine Medical Association the representative of one book firm, and I had quite a talk with him. Many of the book firms are disgusted with the book reviews that appear in the state journals. I can appreciate that fact. If you read a few of them, you could see why.

I have taken it upon myself as a sort of a hobby, in my spare time, after practicing gynecology in the daytime, obstetrics at night and the *Journal* week-ends and Sundays, to write book reviews. I can read them, not quite as fast as Morris Fishbein! "The Life of Harvey Cushing" took me several weeks and it was well worth reading.

If you get somebody who will write book reviews that are worthwhile, you will be able to interest the men in the state in the books that the publishers are putting out, and they in turn will be glad to do their part in getting the books into your state and give them out for review, and they will also come to your meetings and present them.

Now, I can think of many more problems, but the time is short. I would be glad to answer any questions that you may have.

Let me close by saying that if you want to have a good Journal, one that is informative, one that does the job that it should do, you must find one or more physicians in the state who are interested first, and I would say qualified secondly, because if the interest is there, the qualifications will certainly be there.

I never had any training in an editor-ship, not much training in English, except as one gets it in a college course of four years. I did have a little training in advertising when I was in college. When they dumped that job on me eleven years ago, I was alone and I was asked to start the *Journal;* I had to ride around the State and get advertisements, and I had to find out how I could get them nationally, and I had to start the thing rolling. It has been a lot of fun, though.

CHAIRMAN COBB: Thank you, Dr. Weld.

DR. PLUMMER: In regard to the dues for the coming year, it doesn't make any difference to me what the dues are; they are paid for life. So I am not interested, financially. But, the budget, as I recall it yesterday, amounted to $21,000 in round figures. Present dues would give us $24,500 at $35.00, so that we would be that much to the good.

Now, at the present time, there is approximately $38,000 in the Treasury. Just what advantage it is for this Association to carry a considerable amount of money in assets of one kind or another, I don't know. Of course, back in 1929, we didn't have so much, and that might happen again.

Now, dues at $25.00 would give us $17,500 which, on the present budget, would take out $3,500 from our surplus.

Dues at $20.00 would give us $14,000 and we would be about $7,000 shy.

I have had a good many private conversations with some of the members, and they are not satisfied with what we are getting for our dues.

I, therefore, move, Mr. Chairman, that the dues be fixed for the next year at $25.00, and I wish that somebody would amend the motion and make it $20.00.

CHAIRMAN COBB: You have heard the motion. Gentlemen. What is your pleasure? Is there a second to that motion.

DR. PLUMMER: I will withdraw the motion.

CHAIRMAN COBB: Is Dr. Giddings, the delegate from Massachusetts present? He was here.

We are now about to adjourn until the fall meeting, which we decided yesterday afternoon to have this year. I promise you that we will have the order of business and what is to be brought up at the House of Delegates in your hands before the meeting, so that you will know something about what is going to take place, and what will be discussed.

Is there any further business to come before the meeting? If not, a motion to adjourn is in order.

DR. SWETT: I move that we adjourn.

This motion was duly seconded and was carried.

(Whereupon, the Second Meeting of the House of Delegates was adjourned at 6.55 o'clock.)



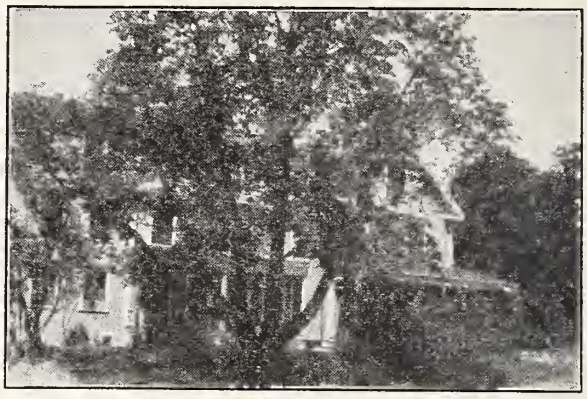
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